1. Reference is made to your presolicitation notice MDA906-02-R-0006 (Received 5 Aug 2002)

The notice states that the West Region contains certain Texas zip codes that are included in the catchment area of Cannon Air Force Base. The TMA Catchment Area Directory, located at http://www.tricare.osd.mil/, indicates that all of the Texas zip codes have been terminated from the Cannon Air Force Base catchment area. Please clarify.

RESPONSE: When Cannon AFB was an inpatient facility, there was a carve-out of 6 Texas zip codes within 40 miles of Cannon (79009, 79035, 79053, 79325, 79344, 79347) placing them in the Central Region. Cannon downsized April, 1999, and these zips were mistakenly transferred from the Cannon catchment DMIS 0085 (Region 7) to Texas state non-catchment 0993 (Region 6). However, those Texas zip codes were transferred back to the Central Region under New Mexico state non-catchment DMIS 0932, where they remain to the current time. The West Region under the new contract will continue this Texas carve-out.

2. In reference to the solicitation that was released on August 1, 2002, can you please tell me the following incumbent contractor information:
(Received 2 Aug 2002)

Contractor(s):
Contract #:
Est. Value:
Award Date:
Exp. Date:
Contract Type:

RESPONSE: The contract type for current Managed Care Support contracts is firm fixed price for the administrative portion and fixed price redeterminable for health care.

Contract No.	Contractor	Award Date	Exp Date	Award Amount
MDA906-97-C-0005	Sierra Military Health Services, Inc.	30 Sep 97	31 May 03	$1.3 Billion
MDA906-97-C-0005	Humana Military Healthcare Services,Inc.	12 Sep 97	30 Apr 03	$3.2 Billion
MDA906-96-C-0002	Humana Military Healthcare Services,Inc.	29 Sep 95	30 Jun 03	$3.6 Billion
MDA906-95-C-0005	Health Net Federal Services, Inc.	28 Apr 95	31 Oct 02	$1.8 Billion
MDA906-96-C-0004	TriWest Healthcare Alliance	27 Jun 96	31 Mar 06	$2.3 Billion
MDA906-95-C-0007	Health Net Federal Services, Inc.	31 Aug 95	31 Mar 03	$2.6 Billion
MDA906-94-C-0003	Health Net Federal Services, Inc.	8 Sep 94	29 Feb 04	$493 Million

3. I do a newsletter for Army retirees (Army Echoes). I would like to mention the contract release in the issue I'm getting ready to publish. When do the new contracts take effect? How will beneficiaries be notified that they have a new contractor. Will one contractor cover all TRICARE for Life beneficiaries (the dual fiscal intermediary contract)? How will a contract integrate all national retail pharmacy services?
(Received 1 Aug 2002)

RESPONSE: On the TRICARE solicitation web site, Section B of the Managed Care Support (MCS) request for proposals (RFP) contains the schedule for each area of contract implementation. The unofficial chart below depicts the schedule in an easier format.

Regions	Current Regions	Start of Health Care Dates
North	Region 2/5	June 1, 2004
	Regions 1	September 1, 2004
South (plus foreign, CHCBP)	Region 6	November 1, 2004
	Regions 3/4	August 1, 2004
West	Region 11	April 1, 2004
	Regions 9/10/12 (Alaska)	July 1, 2004
	Region Central	October 1, 2004

When the new MCS contracts are implemented, the current seven MCS contracts covering 12 CONUS and 3 OCONUS regions will be consolidated into three contracts. The new contracts are designed to assist the direct-care system in coordinating health care delivery in the covered areas and ensure the optimal use of military treatment facility capacities. Beneficiaries will be advised of any change in contractor through briefings, press releases, and publications such as yours.

The Government does plan to award one contract to provide fiscal intermediary services for all TRICARE/Medicare dual-eligible beneficiaries (overseas beneficiaries are excluded). The draft statement of work for this proposed RFP is available on the TRICARE web site at http://www.tricare.osd.mil/pmo/t-nex/.

The Government intends to issue a separate contract for all retail pharmacy services. The retail pharmacy contract will integrate pharmacy services by providing links to each beneficiary's catastrophic cap and deductible files and the Defense Enrollment Eligibility Reporting System (DEERS) through the Department of Defense Pharmacy Data Transaction Service software. This single retail pharmacy contract, which will begin at the same time as the MCS contracts, also will eliminate problems in obtaining prescriptions while traveling, ensure that potential drug interactions are resolved consistently and reduce the Government's cost for drugs.

4. The contract in effect in 1996 when we returned from OCONUS included prevention programs and workshops--Stress Management, Couples Communication, Reunion Issues, etc--and a staff member available to develop and present programs tailored to our base population needs. As a professional working with military families in today's dangerous world, I wonder if this valuable service is being reinstated in the new contract? I believe if someone did a needs assessment of the military base service providers and users, they would find a high demand for this.
(Received 1 Aug 2002)

RESPONSE: Services of the type you referenced will not be required in the Managed Care contracts, although an offeror could include these types of programs as a possible enhancement to their proposal. This does not mean that these services will not be available. Rather, the Department's leadership has determined that it is in everyone's best interest to allow MTF Commanders to determine which services should be provided with MTF resources and which should be purchased.

5. Are there any incumbents from other three previous existing contracts, if any? (Received 5 Aug 2002)

RESPONSE: Please refer to the TMA world wide web page at http://www.tricare.osd.mil for the current operating structure and the incumbent contractors. TRICARE currently has twelve regions which are supported by 7 managed care support contracts. Four companies currently hold these seven contracts. Further details are available through the web site – select either the TRICARE Map or the Links/References on the left side of the home page.

6. Is any portion of the RFP MDAS906-02-R-0006 available in electronic files? Do you have the zip codes of the eligible population so we can determine best provider match? Do you require certain mileage parameters to providers from home zip codes?
(Received 6 Aug 2002)

RESPONSE: The entire RFP is electronic. It is available through the World Wide Web at http://www.tricare.osd.mil/contracting/healthcare/solicitations/MCSS. Detailed data in support of this RFP, such as zip codes, may be purchased by following the instructions contained in the RFP Section L-12.f.(4)(b). We do have access standards for providers. These are contained in 32 C.F.R. 199.17 which is available on the TRICARE web site at http://www/tricare.osd.mil/ and using the pull down select MANUALS (TRICARE) The access standards are at 32 C.F.R. 199.17 (p)(5).

7. A copy of all Justifications and Approvals (J&As) and all Determinations and Findings (D&Fs) that have been approved for this RFP are requested.
(Received 2 Aug 2002)

RESPONSE: The D&F is posted on the TRICARE MCS solicitation website.

8. What kind of changes, if any, are planned for the Uniformed Services Family Health Plan under the new managed care support services contracts?
(Received 9 August 2002)

RESPONSE: The Uniformed Services Family Health Plan is separate and distinct from this solicitation. If and when a separate solicitation is issued, it will outline the program as well as the Government's requirements.

9. Subsection L.10.c. states: Offerors shall submit their anticipated organization structure fifteen calendar days prior to the submission of proposals. This document must include the prime contractor and major first tier subcontractors. The organization structure shall include addresses and telephone numbers. In the case of a joint venture or other business structure, a clear description of the organizational relationships must be disclosed.

We understand that Subsection L.10.c. requires pre-proposal submission of the offeror's anticipated organization structure, but the legal formation of that organization structure, including any required regulatory approvals, can be consummated at any time before award. Is this correct? (Received 9 August 2002)

RESPONSE: Yes

10. Subsection L.10.c. permits an offer to be submitted on behalf of a joint venture. We understand that this includes a "limited" or "contract" joint venture established solely for the purpose of performing the contract. Is this correct?
(Received 9 August 2002)

RESPONSE: Yes

11. Subsection L.11.c states: The Government will award three contracts for managed care support services to three different sources under this solicitation. There will be one area per contract award. All prospective offerors may submit a proposal for any one or all three of the contract areas; however, no one offeror will be awarded more than one contract. For purposes of this solicitation, no offeror, its parent or subsidiary, or a company directly related to the offeror through common ownership, control or management by a parent company, (considered a "related entity" for purposes of this provision) may be awarded another contract if the offeror is awarded one contract under this solicitation. If an offeror is awarded a contract, a related entity may not in any manner underwrite health care under the award of another contract pursuant to this solicitation. If an offeror is awarded one contract, this restriction does not prohibit a related entity from acting as a subcontractor for the provisions of services (other than those involved in the underwriting of health care) under another contract award.
We understand that Subsection L.11.c applies to any offeror that is awarded a prime contract under the solicitation and such offeror's related entities, and it does not restrict a company that is not a prime contractor or related entity. Therefore, a company that is not a prime contractor or related entity could act as a subcontractor under more than one prime contract and in that capacity could underwrite health care in more than one area. Is this correct? (Received 9 August 2002)

RESPONSE: You are correct. Underwriting health care will no longer be a consideration as a prime or subcontractor. In a future amendment to the RFP, the Government intends to replace L.12.c with the following (Note that L.11.c was renumbered to L.12.c. by Amendment 0001.):

"To foster an adequate number of viable contractors in order to reduce the risk to stability in administration of the TRICARE program and to ensure the continuous availability of health care services for TRICARE beneficiaries, the Government will conduct a full and open competition under this solicitation after the exclusion of sources. Therefore the Government will award three contracts for managed care support services to three different prime contractors under this solicitation. There will be one TRICARE Region (i.e., geographical area for contract performance) per contract award. Any offeror will be permitted to compete for one, two, or all three contracts; however, no prime contractor will be awarded more than one contract. The selection of three different prime contractors will occur even if a potential prime contractor submits the best proposal for each of the three contract Regions. If a potential prime contractor submits the best proposal for more than one contract

Region, the Government shall decide which one of the contracts to award to that prime contractor as determined to be in the best interests of the Government.

The Government will, subject to the limitations of FAR 9.604, recognize the integrity and validity of contractor team arrangements provided the arrangements are identified and company relationships are fully disclosed in an offer. For purposes of exclusion of sources under this solicitation, a company or business entity identified in an offer as a potential prime contractor shall be considered to include the named company or business entity, its parent or subsidiary, or a company or business entity directly related to the company or business entity through common (regardless of the percentage) ownership, control or management (whether by a parent company or otherwise). Under this solicitation, no company or business entity may be awarded more than one contract as a prime contractor. In addition, if a contract is awarded to a prime contractor in which a company or business entity has formed a business arrangement (e.g., partnership, joint venture, etc.) to act as a prime contractor, any offeror which includes that company or business entity in a business arrangement to act as a potential prime contractor shall be excluded from award of the other two contracts under this solicitation. A company or business entity, however, may be awarded a contract as a prime contractor in one TRICARE Region and team with a potential prime contractor as a subcontractor in either one or both of the other contracts awarded under this solicitation."

12. We understand that Subsection L.11.c. defines a "related entity" as the offeror, its parent or subsidiary, or a company directly related to the offeror through common ownership, control or management by a parent company. Therefore, a partnership, joint venture or consortium, which includes an offeror in one region, but which is not owned, controlled or managed by the offeror's parent is not a related entity for purposes of Subsection L.11.c. and could be awarded a prime contract in a different region area even if the offeror is awarded a prime contract in the first region under this solicitation. Is this correct? (Received 9 August 2002)

RESPONSE: In a future amendment to the RFP, the Government intends to replace the language contained in L.12.c with the replacement language provided in the response to question #11. (Note that L.11.c was renumbered to L.12.c. by Amendment 0001.)

13. Subsection L.11.c permits a related entity to act as a subcontractor for the provision of services (other than those involved in the underwriting of health care) in a different region even if the offeror is awarded a prime contract under this solicitation. We understand that the services involved in underwriting health care are those described in Subsections H-1(a)&(b), and they do not include the activities specifically excluded in Subsection H-1(d). Therefore, a prime contractor or a related entity to a prime contractor in one region could act as a subcontractor in a different region and could engage in medical-management activities, such as case management, disease management, and utilization management, and administrative activities such as network development and maintenance, management of TSCs, billing and enrollment, non-claims customer service, contract administration and resource sharing under the subcontract. Likewise, the subcontract could include positive and negative incentives similar to those set forth in Sections H-8 & H-9, including performance guarantees and award fees relating to medical-management activities. Is this correct? (Received 9 August 2002)

RESPONSE: You are correct. In a future amendment to the RFP, the Government intends to replace the language contained in L.12.c with the replacement language provided in the response to question #11. (Note that L.11.c was renumbered to L.12.c. by Amendment 0001.)

14. It sounds like the Resource Sharing program under the new contract will be a little different product from the current one. Can you clarify which party will be paying for this program (e.g. individual MTF)? Is this going to replace the Resource Support program? What will happen to the current Resource Sharing program/projects during transition period? (Received 9 August 2002)

RESPONSE: Resource Sharing, in concept remains the same. That being that when it is in the best interest of the Government and the MCSC, the MCSC will provide resources to augment the military treatment facilities capability. The MCSC will be reimbursed for all allowable costs associated with resource sharing per Section H-4.b. of the RFP. The MCSC may earn additional revenue as a result of these agreements based on the reduction in actual costs resulting from the civilian health care costs avoided by the resource sharing agreement. This program will replace the Resource Sharing financing mechanisms that exist in the current seven contracts. The existing Resource Sharing agreements will terminate with the expiration of the current MCSC contracts. There is no requirement for the successful offeror to negotiate new agreements to continue the services, but may do so if the parties determine if it is a win-win situation. The Government intends to review each existing Resource Sharing agreement to determine its value and if value exists, the Government will consider obtaining the services under a new resource sharing agreement, or through mechanisms outside of this solicitation. The Resource Support program will not continue under the resulting contracts of this RFP.

15. Please provide the most recent Service Contract Act (SCA) labor rates incorporated by contract modification for all regions other than the TRICARE Central Region. We do understand that SCA rates are not a requirement in this RFP. (Received 10 August 2002)

RESPONSE: This information must be requested, in writing, through the Freedom of Information Act process.

16. Does this solicitation contain any opportunities for facilities that provide Laser Vision Correction to subcontract to your contractors that win the bid? (Received 13 August 2002)

RESPONSE: There will be an opportunity to become a network provider of a potential bidder or bidders on the new Managed Care Support Contracts. The Government does not know at this time who those bidders will be but usually those companies contact potential interested providers who are not already in their commercial networks. However, based on the name of your company you might not be needed in a network as the TRICARE benefit does NOT cover laser surgery for corneal sculpting procedures to correct vision acuity.

17. According to attachment L-2 the zip codes for the new regions and the exclusions and inclusions are in Section J-4, Document XX, I can't seem to find Section J-4, Document XX anywhere. Can you point me to the right place to obtain these zip codes? (Received 14 August 2002)

RESPONSE: The zip codes are contained in the data tapes described in Attachment 8 listed in Section J. To obtain the data tapes, submit a written request (can be email) to the Contracting Officer. The reference to Section J-4, Document XX in Attachment L-2 has been corrected in amendment 0001 to the solicitation. Refer to Section F, paragraph F-4 for geographic area of coverage and Section L, paragraph L-12f(4)(b) for information regarding the data tapes.

18. Section G-3b. Contractor payments disbursed by the MTF - Section (c) states, "The contractor may submit to the appropriate MTF a monthly consolidated invoice of passed (i.e. non-rejected) TED records. TMA reporting will provide the regular daily postings of data by DMIS ID and from these postings the appropriate MTF can check against the contractor invoice. The MTF can then approve the invoice for payment and forward to DFAS for payment." We have the following questions regarding this section: (Received 15 August 2002)

a. The section states that the contractor "may" submit a monthly invoice to the MTF. Therefore, we assume that the contractor may submit invoices in a more frequent manner such as weekly as the MTFs will have access to the TEDs through TMA as they clear on a daily basis. This would also allow for a thorough review of the claims in a timely manner. Please confirm.

RESPONSE: The contractor may not submit invoices more frequently than month. The Section G-3 will be extensively revised in a future amendment and will clarify the process for submission of invoices.

b. We assume we would submit a periodic DD250 to the various MTFs which would be addressed to DFAS which they would they would forward to DFAS for payment. FAR 52.232-25 Prompt Payment would give the MTF 7 days to approve and send the invoice to DFAS. Please confirm that the MTF will operate under this section of the FAR.

RESPONSE: ***Revised 20 September 2002***

Yes. Section G-3 will be revised in an amendment.

c. Under Section G-3a.(3)(l)[1] of the RFP regarding Underwritten Health Care Costs it states "Payment of underwritten healthcare health care cost claims will be made to the Contractor after the associated TEDs clear all edits. Payment Terms: Net 3 (following clearing all edits)". Section G-3.b. involves the payment through DFAS for the MTF enrollees going to the civilian sector. Since these costs are still underwritten can we assume that DFAS will pay the invoices on a net 3 basis? Please confirm.

RESPONSE: Section G-3 will be revised in an Amendment.

19. Section G-3b. Involves disbursements through the Defense Finance and Accounting Services (DFAS). (1) States that "This section covers civilian sector claims for both revised financing - MTF Prime enrollees and also Active Duty supplemental care." Chapter 19 Section 4 paragraph 2.0 of the August 2002 Operations Manual indicates that these ADSM costs will be

reimbursed to the contractor according to Chapter 3, Section 3 of the Operations Manual. Chapter 3 Section 3 involves payments by TMA through the submission of TEDs vouchers through the Federal Reserve Bank provisions. We assume that the Operations Manual would apply. Please confirm.
(Received 15 August 2002)

RESPONSE: Your assumption is not correct. The language in the RFP Section G-3 will be revised to clarify the process.

20. The on-line manuals are not the ones referenced in MDA906-02-R-0006. Can you help me located the TOM, TPM, TRM, and TSM that are dated August 1, 2002?
(Received 15 August 2002)

RESPONSE: We assume you have accessed the manuals that are in effect for the current Managed Care Support contract. Please access http://www.tricare.osd.mil/contracting/healthcare/solicitations/ and select the solicitation number MDA906-02-R-0006. Select Referenced Manuals. These are the manuals that will be used for this solicitation.

21. The following questions pertain to Section C of the solicitation
(Received 15 August 2002)

a. C-7.1.16 - Does the requirement for *specialty providers* to provide the MTF with consultant reports within 5 days include behavioral health? If yes, what if the beneficiary refuses to provide consent?

RESPONSE: Yes, the provision applies to all types of care. However, if the beneficiary refused to release the information to their primary care provider, the specialty care provider must notify the primary care provider of this fact, in writing, within the established timelines.

b. C-7.5 - Will the mental health subcontractor be expected to convey UM decisions for MTF enrollees to the MTF commander if care is received outside the MTF (inpatient)?

RESPONSE: The Government is contracting with a single source, per region, to provide the services required in this RFP. As such, the provisions of this RFP will apply to the contractor with whom we eventually contract. If the "prime" contractor elects to subcontract a portion of the required work, the subcontractual relationship does not in any way alter the Government's requirements.

c. C-7.1.2 – Does this requirement that non-network MTF referrals are to be sent for Regional Director approval also pertain to mental health?

RESPONSE: Yes. Please see our previous response.

d. C-7.39 – Does this requirement apply to behavioral health? Clarify that the expectation is that the contractor will provide the clinical information to the MTF when referring a beneficiary into the MTF for treatment.

RESPONSE: Yes, the contract requirements apply to mental health care. The requirement is not to provide clinical information. Rather, the requirement is to

provide management information sufficient to allow the MTF Commander to promptly assess the workload leaving the MTF.

e. C-7.28 - Must the mental health subcontractor (1st tier) locate a senior executive with the authority to obligate the contractor's resources within a 15-minute drive of the Contracting Officer's office? Or is this requirement only for the Prime contractor?

RESPONSE: Again, we contract with a single entity. It is this entity that must locate a senior executive within 15 minutes of the Regional Director's office. This individual must be able to fulfill the contract requirements regardless of any subcontractual relationships the prime contractor may elect to employ.

f. C-7.28 - Where will the Regional Directors' offices be located for each region?

RESPONSE: ***Revised 9 September 2002***

There will be three Regional Directors in CONUS. The planned locations are Washington, D.C.; San Antonio, Texas; and San Diego, California. Overseas is not relevant to this RFP.

g. C-2.1 (statement of objectives) - What services will be required by the contractors for active duty service members (example: utilization management, case management, referral services, both in the direct and indirect setting, exclusive of TPR and SHCP)?

RESPONSE: The requirements are specified in the RFP and the associated manuals.

h. C-7.3.3 – Will data from treatment at the MTF be available to the contractor in a timely manner to be included in required HEDIS measures?

RESPONSE: ***Revised 26 September 2002***

The requirement to comply will HEDIS will be removed in a future amendment. Quality assurance performance measures will be monitored by the Government and reported to the contractor through the Lead Agent; see the amendment.

i. C-7.26 – Will the on-site Government representative be capable of clarifying on behalf of TMA or the MTF on TRICARE-related issues?

RESPONSE: The on-site person will NOT be a Contracting Officer and will have not authority to obligate the Government or direct the contractor to perform. The individual will serve as a contracting officer's representative; however, their authority will be limited based on the written delegation they receive from the Contracting Officer. The on-site individual will have the authority to monitor contractor performance.

22. How do I register for the presolicitation conference on the 28th?
(Received 16 August 2002)

RESPONSE: There is a notice on the TRICARE website, http://www.tricare.osd.mil/contracting/healthcare/solicitations/MCSS, regarding the pre-proposal conference. Instructions on how to register are posted in the notice.

23. RFP Section B, page 2 West Contract-Option Period I - The Option Period dates are shown as 1 April 2004 - 31 March 2004. Should the end date be 31 March 2005? (Received 16 August 2002)

RESPONSE: Yes

24. RFP Section B, 0103AB, page 2 indicates the paper claims rate is 9,550,442. Should the paper claim rate read 955,044 as indicated on Attachment L-8? (Received 16 August 2002)

RESPONSE: Yes. The paper claims rate was revised in Amendment 0001.

25. RFP Section B, page 2 West Contract – Option Period I - CLIN 0104AA states the "First 6 months contract period" as 15,415,560 PMPM. The PMPM appears to be calculated based on a full six months of estimated beneficiaries for all areas to be transitioned. As we understand Option Period I, the first six months will result in a phase-in beginning with Geographic Area 11 for 6 months, Geographic Area 9/10/12 for 3 months and Geographic Area Central does not begin until the start of the second 6 month period. Therefore, should the PMPM counts be calculated based on dates from start of healthcare, i.e. the dates stated above? Similar situations appear in the South and North contracts.
(Received 16 August 2002)

RESPONSE:

26. RFP Section B, CLIN 0103AA and 0103AB, page 2
This CLIN provides the estimated claim volume for electronic and paper claims. The data is also provided in Attachment L-8.
Based on Attachment L-8, the number of electronic claims is 85%, suggesting that either pharmacy or TFL claim volumes are part of these estimates. Is that correct or are these estimates based on the RFP requirement to have all provider claims submitted electronically? (Received 16 August 2002)

RESPONSE: Pharmacy and TFL claim volumes are not part of these estimates. Projections were based on several factors to include the effects of requiring all network providers to file electronically and the implementation of the Transaction and Code Sets requirements of HIPAA.

27. RFP Section B, page 3 West Contract, CLIN 0105AA Estimated cost = $2,000,000 (Government provided estimate). It appears this estimate is based on a full year, whereas Option Period I is phased-in, such that all contract areas will not be operational for the full period. Does the Government still want the contractor to use the full $2,000,000 for Option Period I? Similar situations appear in the South and North contracts. (Received 16 August 2002)

RESPONSE: Yes

28. RFP Section C-7.7 page 27, last sentence states: "The contractor's medical management program must fully support the services available within the MTF." Can the government please expand on this requirement? For example, will the MTFs make data available to the contractor to implement the contractor's medical management programs? Are these issues the Government would expect the Contractor and MTFs to work through as part of the MOU?

(Received 16 August 2002)

RESPONSE: Historical Direct Care data is contained in the Data Package, Section J, Attachment 8. In addition, it is expected that the contractor's medical management program model will be designed to optimize the MTF services following the requirements of the RFP and the program. The proposed program and its design are at each offeror's discretion.

29. RFP Section 7.9, page 27 - Please provide any workload volumes relative to the enrollment activities of TRICARE Plus? (Received 16 August 2002)

RESPONSE: TRICARE Plus Enrollment By Region – as of 20 Aug 02

Region		Total Enrolled
HSR	01	27,404
HSR	02	7,206
HSR	03	15,083
HSR	04	9,521
HSR	05	9,323
HSR	06	19,218
HSR	07	3,381
HSR	08	7,009
HSR	09	8,347
HSR	10	4,246
HSR	11	8,473
HSR	12	2,783
HSR	13	8,281
HSR	14	1,712
HSR	15	1

Enrollments at the end of the Month for all regions:

Oct 2001	35,916
Nov 2001	62,277
Dec 2001	84,014
Jan 2002	100,270
Feb 2002	115,165
Mar 2002	119,217
APR 2002	123,413

MAY2002 127,102
Jun 2002 128,548
JuL 2002 131,216

30. RFP Section C-7.12.& C-&.15. pages 27 & 28, Will beneficiaries currently enrolled to a network PCM under the present contract be required to transfer enrollment to an MTF PCM if capacity exists at the start of the new contract or anytime during the term of the new contract?
(Received 16 August 2002)

RESPONSE: ***revised 20 September 2002***

RESPONSE: In an upcoming amendment, Section C-7.15. will be changed to read, "If a beneficiary's civilian primary care manager remains in the TRICARE network, the beneficiary may retain their primary care manager. If the beneficiary must change primary care managers, all enrollments shall be to the MTF until MTF capacity, as determined by the MTF Commander, is reached.

31. RFP Section C-7.3.2., page 26, states "Ninety-six percent of referrals of MHS beneficiaries, residing in TRICARE Prime service areas who seek care through the contractor, shall be referred to the MTF or a civilian network provider. This percentage shall include services rendered in network institutions by hospital-based providers even though no formal referral was made to that individual." The occurrence of Hospital-based providers not signing agreements with managed care organizations (MCO) is a chronic problem in the industry. It is obviously in the best interest of MCOs to negotiate rates, sign agreements, and have these providers become part of their network. Unfortunately, many of these providers never have and never will become network providers. TMA seems to recognize this problem because the quoted Section goes on to state, "The Administrative Contracting Officer may grant an exception to this requirement based upon a fully justified written request from the contractor demonstrating that it is in the best interest of the Government to grant the exception." If it is understood that having these providers participate in the network is in the best interest of the MCO, and that TMA recognizes this as a sometimes insurmountable problem, why is this punitive requirement imposed on the contractor? Will the Government consider amending the RFP and establishing this standard at an achievable level? (Received 16 August 2002)

RESPONSE: The Government has recognized that in some areas of the country obtaining providers for the network is a challenge and has taken that into consideration by several factors: The requirement only applies in Prime service areas (MTF catchment areas and BRAC sites plus those of the contractor's choosing). The requirement applies to only 96% of the referrals and on an exceptional basis (e.g., nonavailability of a subspecialist in the network) the requirement may be waived.

32. RFP Section C-7.9., page 27, states, "The contractor shall meet with and establish a Memorandum of Understanding with the Marketing and Education Contractor in accordance with the TRICARE Operations Manual, Chapter 16, Section 1 specifying the frequency, type, and content of information the contractor shall provide the Marketing and Education contractor." There is no mention of this requirement in Chapter 16, Section 1 of the TRICARE Operations Manual 6010.51-M, August 1, 2002. Please clarify. (Received 16 August 2002)

RESPONSE: The correct reference is Chapter 12, Section 1. Corrected in Amendment 0001.

33. RFP Section C-7.39., page 32, states, "The contractor shall provide each MTF with referral information concerning any MTF enrollee within 24 hours of a referral." Please specify the type of referral information expected. (Received 16 August 2002)

RESPONSE: The information shall include the name of the enrollee, date of referral, and the service for which the beneficiary is referred.

34. RFP Section C-7.42, page 33, states, "The contractor shall provide pharmaceuticals to beneficiaries in situations where the pharmaceuticals are not obtained from a retail pharmacy and consistent with the coverage usually provided under an outpatient pharmacy benefit."
Please identify the type and expected volume of pharmaceuticals that are not provided through retail pharmacies, the TRICARE Mail Order Pharmacy or from specialized pharmacies? (Received 16 August 2002)

RESPONSE: An example of a non-retail, non-mail order prescription would be an initial supply of drugs filled from a hospital pharmacy upon inpatient release. Another example would be solutions or medications provided during a home health agency visit. The Government does not separately identify these pharmaceuticals.

35. RFP Section C-7.1.1, page 24 states "The contractor's network shall be accredited by a nationally recognized accrediting organization no later than 18 months after the start of health care delivery in all geographic areas covered by this contract. When this contract and the accrediting body both have standards for the same activity, the higher standard shall apply." The government mentions NCQA as the recognized organization for HEDIS, does the government recognize NCQA as the accrediting organization for the contractor's network? What accrediting organization does the Government accept as being "nationally recognized"?
(Received 16 August 2002)

RESPONSE: Generally, some of the nationally-recognized accrediting networks by the industry are NCQA, URAC, and JCAHO. The Government is not directing that a specific accrediting organization be used for TRICARE.

36. RFP Section C-7.20.2., page 28 states "The contractor shall establish twenty-four hour, seven days a week, nationally accessible (to include Hawaii and Alaska) telephone service, without long distance charges, for all MHS beneficiaries seeking information and/or assistance with urgent or emergent care situations. This function shall be accomplished with live telephone personnel only."
Please clarify if this is considered a Health Care Information Line (HCIL) or a beneficiary information line for general plan information which includes location of network providers? (Received 16 August 2002)

RESPONSE: It is not a HCIL triage line but will provide information that will assist beneficiaries in locating the nearest providers, preferably network, during an urgent situation.

37. RFP Section C-7.33, Page 31, states: "The contractor shall implement processes and procedures that ensure full compliance with the "Presidents Advisory …."

The process and procedures contained in this report have not been enacted as of this date. Some of the procedures appear to be inconsistent with requirements of the RFP. Examples are access to specialist and the requirement for beneficiary survey for disclosure of health information. Please clarify the specific standards and process, if any, to be met. (Received 16 August 2002)

RESPONSE: For access to specialists, the commission stated "Access to Specialists. Consumers with complex or serious medical conditions who require frequent specialty care should have direct access to a qualified specialist of their choice within a plan's network of providers. Authorizations, when required, should be for an adequate number of direct access visits under an approved treatment plan." We do not find this inconsistent with the RFP. We are unable to identify specific instances of inconsistencies; please provide. The requirement stands regardless of whether or not the report has been enacted.

38. RFP Section F.5 Page 37, RFP states: "All reports shall be submitted electronically in Microsoft 97 Excell….." Would the Government consider amending the solicitation to state "All reports shall be submitted electronically in Microsoft 97 Office Suite and in a secure manner to the Government unless otherwise specified. (Received 16 August 2002)

RESPONSE: The Government will revise the current language in paragraph F.5. via a future amendment.

39. RFP Section G-3.b. (1) (c), page 43
The RFP states: "The contractor may submit to the appropriate MTF a monthly consolidated invoice of passed (i.e. non-rejected) TED records…… "The MTF can then approve the invoice for payment and forward to DFAS for payment."
Please provide additional information about the format and details for MTF acceptance of the contractors invoice?
Please explain the Governments payment terms for this invoice?
Please explain the Governments process for resolution of invoice issues?

RESPONSE: An amendment to the RFP will clarify this provision.

40. RFP Section H-8.1, page 51 states "Standard: Not less than 96 percent of contractor referrals within a Prime service area shall be to a MTF or network provider with an appointment available within the access standards." The contractor will attempt to optimize the use of the MTF by referring contractor enrolled beneficiaries to the MTF, but it is beyond the control of the contractor, if the MTF fails to provide access to care within the standards. Please clarify any specification about this standard. (Received 16 August 2002)

RESPONSE: If the MTF cannot provide the appointment within the access standards, then the contractor is required to provide a referral to a provider who has an appointment within the access standards.

41. Attachment J-2, page 8, Section VI states "Retired beneficiaries enrolled in Medicare Part B may have their enrollment fees waived if they provide a copy of their Medicare card as proof of enrollment in Medicare Part B." Is a retired beneficiary who is enrolled in Medicare Part B required to enroll in TRICARE Prime to receive TRICARE For Life benefits? (Received 16 August 2002)

RESPONSE: No.

42. Attachment J-3, page 3, Section II, 1,d, lists one reason for filing a disenrollment form to be "Loss of Prime eligibility due to turning 65 years of age." Is it necessary for a Prime enrollee to fill out a disenrollment form upon turning 65 or is it the loss of Prime status automatic? (Received 16 August 2002)

RESPONSE: A beneficiary may fill out the disenrollment form (which is still in draft form) upon turning 65; however, this is unnecessary as NED will automatically remove an enrollee from Prime on DEERS and notify the contractor of the action.

43. RFP Attachment L-1, Page 2, first paragraph states the South Contract will accept and process claims from all Medicare eligibles that are residing overseas. Currently, WPS is the claims vendor for the overseas PRIME/Standard beneficiaries. Please clarify whether WPS is currently processing the Medicare overseas claims, and if so, as primary or secondary payer for the overseas operation?
(Received 16 August 2002)

RESPONSE: HMHS is processing all claims received for overseas medical care rendered to beneficiaries who are eligible for Medicare. Generally, TRICARE is primary payer as no Medicare benefits are available overseas.

44. RFP Attachment L-1, page 3, last bullet point: Performing customer service activities for all beneficiaries in the Region, including those NOT eligible for TRICARE reimbursable benefits in the civilian network, but who have a need to know about their military health benefits and how to access services to which they are entitled. Please clarify what is meant by "those not eligible for TRICARE reimbursable benefits in the civilian network, but who have a need to know…" (Received 16 August 2002)

RESPONSE: The contractor is required to assist all MHS beneficiaries who request assistance in understanding their benefits (Section C-7.16). This includes those beneficiaries who may have MTF access but do not have TRICARE health care coverage outside of the MTF; e.g., parents, parents-in-law.

45. RFP Attachment L-1, page 3; attachment L-2. The Executive Summary (attachment L-1) refers to the contractor's responsibility to actively assist the Regional Director and MTF Commanders.
Attachment L-2 (Regional Descriptions) states "The following three contracts are for assisting the Lead Agents/MTF Commanders in coordinating health care deliver in the covered regions …"
Will the government please explain the organization structure and how the Regional Director and Lead Agents will work with the contractor, or will the Regional Directors office replace the Lead Agents offices? (Received 16 August 2002)

RESPONSE: The final governance structure has not yet been determined. There will be three Regional Directors and the existing Lead Agents will continue to be a key part of the overall governance structure. The Regional Director will be primarily responsible for the contract oversight and execution. The Lead Agents will be responsible for supporting the business plan that provides for patient care services in their area of responsibility (AOR). The Lead Agent will be focused on utilization of the military direct care system but will continue to have a working relationship with the contractor in regard to the purchased care for the MTF's in their AOR.

46. RFP Attachment L-3, 5.3.2.3 states "The contractor will have the opportunity to provide written input to the Award Fee Board." Will the contractor have the opportunity to review the surveys and any comments prior to the Board meeting to develop any input they might have? (Received 16 August 2002)

RESPONSE: The ACO, as directed by the Award Fee Determining Official, will request input from the contractor. It is their discretion what input will be requested and what information will be shared.

47. RFP Section L.11.c, page 81 - The RFP states: "All prospective offerors may submit a proposal for any one or all three of the contract areas; however, no one offer will be awarded more than one contract." If an offeror chooses to submit proposals for more than one contract areas, please explain: (Received 16 August 2002)

a. Does the offeror submit multiple Technical/Performance Standards and Past Performance Proposals and Oral Presentations materials, one for each contract area?

RESPONSE: Yes

b. Does the offeror receive Oral presentation time-slots for each contract area?

RESPONSE: Yes

c. A related question, please explain the Governments rational for limiting an offerors ability to assuming underwriting risk in only one contract region

RESPONSE: The D&F that will answer this question is posted on the solicitation website (http://www.tricare.osd.mil/contracting/healthcare/solicitations/MCSS). Select "Questions and Answers"; then select "Answer to Question 7."

48. RFP Section L.12 c., page 82 - This RFP citation states: "The documents listedbelow are to be submitted as separate entities."

Oral Presentation Slides
Technical Proposal
Past Performance Information
Financial Information
Cost Proposal
Subcontracting Plan

The next paragraph of RFP Section L.12.c, states: "The primary component of the technical proposal is the oral presentation. The technical proposal shall be separated into two sections; Section 1-oral presentation slides and Section 2-written documentation required by the RFP. …"
Since the oral presentation slides are part of the Technical Proposal, how can it be "submitted as separate entities"? Can the Government please clarify the construct and submission requirements of the Proposal? Also, please confirm, reference RFP Section L.12.a, page 81, and RFP Section L.12 f. (1) (a), page 87. Does the Government expect to receive only a technical proposal, limited to proposed performance standards and oral presentation slides? Please elaborate if necessary. (Received 16 August 2002)

RESPONSE: The technical proposal consists of two separate entities (sections): the oral presentation slides and the written documentation required by Section L-12f.(1)(a). The written portion of the Technical proposal is limited to the referenced slides and the standards proposed by the offeror.

49. RFP Section L-12.e.(4), page 86, states "The offeror shall specifically state, the percentage of current primary care and specialty providers that will continue to be network providers following the start of health care delivery." Offerors cannot factually make this statement nor offer the best price to the government without electronic listings of providers in the current contractors' networks. Will these listings be made available to offerors? If so, when will this information be provided? (Received 16 August 2002)

RESPONSE: ***revised 26 September 2002***
RESPONSE: The provider directories will be provided.

50. RFP Section L.12 (g) (2) Health Care Prices, page 90
This RFP section states: "Offerors shall propose target health care underwriting fee amount for each option period. The target fees shall be proposed as both fixed dollar amounts and as percentages."
Since the Target Underwritten Health Care Costs are only proposed for Option Period I, please describe how the offeror should determine the dollar amounts for Option Periods II through V. (Received 16 August 2002)

RESPONSE: The Government will not prescribe how offerors should determine the dollar amounts for target health care underwriting fees for Option Periods II through V. The target underwriting fees should be estimated by whatever methodology the offeror chooses. Offerors are reminded that the target underwriting fees for Option Periods II through V will be considered part of the total evaluated price for contract award considerations. The Government expects the reasonableness of the fees to be based on price competition. See Question & Answer # 454 for additonal information.

51. RFP Section M.6.a., page 93, states "Proposals will be evaluated for supporting the optimization of the direct care system through collaborative, DoD directed efforts in areas of medical management, referral management, provider network management, beneficiary and provider education, beneficiary/customer services, data management and data sharing, and resource sharing." Medical Management is defined in the TRICARE Operations Manual 6010.51-M, August 1, 2002, Appendix A, as follows: "**MEDICAL MANAGEMENT:** Contemporary practices in areas such as network management, utilization management, case management, care coordination, disease management, and the various additional terms and models for managing the clinical and social needs of the beneficiary to achieve the short and long term cost-effectiveness of the MHS while achieving the highest level of satisfaction among MHS beneficiaries." Since the terms provider network management and referral management are part of the definition of medical management, it appears that these two terms are used unnecessarily and confusingly in the quoted paragraph of Section M. Please clarify.
(Received 16 August 2002)

RESPONSE: We find nothing confusing about either the paragraph or the definition. The RFP Section defines what a proposal will be evaluated on. The definition of

Medical Management provides some of the traditional practices associated with medical management.

52. RFP Section M.6.c., page 94 states "Proposals will also be evaluated based on the offeror's approaches for achieving the 50th percentile of the NCQA's HEDIS measures based on all reporting plans for TRICARE Prime enrollees who are the fiscal responsibility of the offeror during the first two option periods of the contract will be evaluated." Will Military Treatment Facilities (MTF) be held to the same HEDIS requirements for their enrollees under this contract?
If MTF are not held to this same standard, how will the government meet their goal of continuous health improvement of the TRICARE population? How will the government ensure a "fully integrated patient information system" based on information about the total TRICARE beneficiary population? Today, NCQA HEDIS standards for TRICARE do not exist. Please clarify what NCQA HEDIS standard will be followed – Commercial, Medicare, or Medicaid? (Received 16 August 2002)

RESPONSE: ***revised 26 September 2002***

RESPONSE: The requirement to meet HEDIS measures will be removed in a future amendment. The amendment will also announce quality assurance performance measures that targets both the MTF and civilian enrollees.

53. RFP Section M.4.a., page 92 states "Factor 1- Technical Approach (includes proposal risk)". Please elaborate and clarify as to what is meant by proposal risk? (Received 16 August 2002)

RESPONSE: Proposal risk relates to the identification and assessment of the risks associated with an offeror's proposed approaches to performing the requirements of the contract.

54. C.7.34. If the contractor has one of the current regions and is assuming another portion of that region, do you assume that the gaining contractor could forward the losing contractor's telephone number to its main toll-free number for an adequate period of time for the beneficiary to be educated properly? Please confirm. (Received 16 August 2002)

RESPONSE: No, the requirement is to transfer the rights to the number. The incoming contractor would then assume responsibility for operating the number. The contractor shall ensure that anyone accessing the number is responded to within the requirements.

55. Reference Section L.12.f(2): Please confirm that the information requested in (b) and (c), addressing the narrative on overall past performance, is to be presented separately from the information in (d) through (i), addressing account-specific information. (Received 16 August 2002)

RESPONSE: The information is to be submitted at the same time in a single past performance volume. The 25 page limit applied to the narrative required in Section L.12.f(2)(b) does not apply to the information submitted in response to L.12.f(2)(d)-(j).

56. Reference L.12.f(2)(b): Requests offeror to support "supporting documentation" as part of its narrative on past performance. Please confirm that supporting

documentation will not count toward the 25-page limit. Similarly, L.12.f(2)(f) requests reports and findings on subcontractors from their government accounts; please confirm that these reports/findings will not count toward the page limit. (Received 16 August 2002)

RESPONSE: Supporting documentation was deleted in Amendment 0001. The report submission requirement is not in Section L.12.f(2)(f) but in Section L.12.f(2)(i). In any case, the page limit does not apply to the requirements in Section L.12.f(2)(f) and Section L.12.f(2)(i).

57. L.12.f.(2)(b), Page 87, What is required by the item "Relationship of the experience to the appropriate customer"? What information is the Government looking for?
(Received 16 August 2002)

RESPONSE: If, for example, the offeror's narrative includes claims processing experience, the reference to claims processing experience must include the customer for whom the offeror provided the service.

58. Has the government intentionally excluded moving the TRICARE program to true coordination of benefits rules as was done for TRICARE for Life?
(Received 16 August 2002)

RESPONSE: The RFP is designed to purchase contractor support to manage the Program as defined. Changing TRICARE policy is beyond the scope of this solicitation.

59. Section B - Claims quantities – In the Western Region, Option Period 1 has higher claims quantity than Option Year 2. This seems overstated as the Western Region Option Year 1 contract is only to process 9 months of claims for Regions 9/10/12 and 6 months for the Central Region. We understand that the volumes listed are for evaluation purposes only, but significant over or under estimating of volumes will not give the government a fair estimate of the actual total costs. The claims volume in Schedule B does not agree to Attachment L-8 of the RFP in Option Period 1. Please clarify. (Received 16 August 2002)

RESPONSE:

60. Section B and H - How many months of healthcare should be included in the OP1 target cost? For example, in the South Region, should 9 months of Regions 3/4, and 5 months of the Region 6 be included? If the answer to the above is yes, then for the evaluation of Target Underwritten Health Care Costs, will the costs be annualized for both Regions 3/4 as well as 6 to avoid an unfair competitive advantage between the Regions? (Received 16 August 2002)

RESPONSE: In accordance with the contract schedule, the following number of months of health care should be included in the offeror's target underwritten health care costs for Option Period I. These partial-year costs will NOT be annualized by the Government during evaluations. There is no possible "unfair competitive advantage" since the healthcare delivery period for a particular contract is the same for all offerors.

Area	**Current Region**	**Start of Health Care delivery**	**Number of Months in Option Period I**
North	2/5	June 1, 2004	10
	1	September 1, 2004	7
South	6	November 1, 2004	5
	3/4	August 1, 2004	8
West	11	April 1, 2004	12
	9/10/12	July 1, 2004	9
	Central	October 1, 2004	6

61. C-7.1 Are the network requirements for the Alaska Prime Service Area the same as they are for any other Prime area? (Received 16 August 2002)

RESPONSE: Yes

62. C-7.1.16. Please clarify the return of mental health reports. These could only be supplied if the beneficiary signed a document allowing their release. We would recommend that mental health be excluded from the requirements. Please address these privacy concerns. (Received 16 August 2002)

RESPONSE: ***revised 11 September 2002***

We expect mental health providers to obtain the necessary release and provide the required report. However, if the beneficiary refused to release the information to their primary care provider, the specialty care provider must notify the primary care provider of this fact, in writing, within the established timelines.

63. C-7.1.16. Concerning urgent/emergent specialty consultations being telephoned or faxed within one-hour to the PCM. We assume that this would apply to network specialists only as we would have no way of monitoring or enforcing this with non-network providers. Also, we are concerned about privacy issues if faxes are sent to machines during non-working hours. How would HIPAA privacy standards be accomplished under these protocols? We would recommend within one working day as the standard for network providers. Please address. (Received 16 August 2002)

RESPONSE: ***revised 20 September 2002***

Yes, the requirement specifically states "network specialty providers." We do not believe HIPAA is an issue since every provider's office must already meet the security test required by HIPAA. We have listened to industry and in a future amendment will change the 1 hour preliminary reporting requirement for preliminary referral/consultation reports to being required within 24 hours unless best medical practices require a quicker response time.

64. C-7.14. Will the monthly enrollment allotments be transmitted in the HIPAA compliant 820 transaction? (Received 16 August 2002)

RESPONSE: Yes

65. C-7.16. This section states "The contractor shall have the ability to provide TSC services during periods when access to the TSC physical space is limited or terminated due to weather, war, security, or MTF/Base Commander's decision." Will CHCS access for all MTFs within the Region be allowed to be setup at the contractor's central location in order to meet the TSC requirements which will include MTF assignment by name for enrollment into CHCS and also the receipt of electronic referrals? If not, please amend this requirement to state that the affected MTFs and TSCs would work jointly to provide workarounds for workload impacts due to the unavailability of CHCS to the contractor. (Received 16 August 2002)

RESPONSE: Amendment 0001 changed the manner in which PCM information reaches CHCS. We believe all other requirements can be fulfilled without direct access to CHCS.

66. C-7.21.2. This section refers to beneficiary satisfaction. Is the contractor permitted to query beneficiaries on customer service satisfaction, provided that the information is used for internal purposes and not disseminated publicly? (Received 16 August 2002)

RESPONSE: Yes, in accordance with the provisions of the TRICARE Operations Manual which require approval of surveys.

67. C-17.21.18. This section states, "Amounts paid in excess of the CHAMPUS Maximum Allowable Charge (CMAC), diagnostic related groups (DRG), or prevailing charge to non-network providers shall not be reported or used as health care costs for the purpose of the actual costs reported for health care fee determination under Section H." We assume that this provision is for the purpose of calculating the fixed fee set per year and not for the purposes of minimum and maximum fee calculations. We further assume that these costs are acceptable underwritten costs. Are these assumptions correct? If not, please clarify. (Received 16 August 2002)

RESPONSE: These assumptions are not correct. These costs will not be included in the underwritten amount since, in most cases, they result from network inadequacy.

68. Attachment L-2, Please provide the document referred to as Section J-4, Document XX. In addition, will this document include a description of what is considered the Prime Service Area for each MTF and BRAC site with their associated zip codes? In order to complete the cost proposal, this information is necessary. (Received 16 August 2002)

RESPONSE: The reference to Document XX was removed from the RFP by Amendment 0001. Amendment 0001 clarifies that TRICARE Prime is required in a 40-mile radius surrounding each MTF. Where this is not a "catchment" area, offeror's are required to develop the zip codes covered.

69. Section G(n) and Section H-4 – Resource Support - Resource support is not referred to in the RFP. We assume that this program will not continue under this RFP. Please confirm.

RESPONSE: You are correct, Resource Support will not continue as a component of future Managed Care Support Contracts.

70. Section G-5 - "The Government will unilaterally determine the number of MHS eligibles two times each option period under the Per Member Per Month contract line items, once for the first six month period and once for the seventh through the twelfth month." Will there be an eligible adjustment done prior to the start of Option Year 1? (Received 16 August 2002)

RESPONSE: No

71. Section H-2. - Partial payments of underwriting fee. "During the performance of each option period, the Government will pay the contractor, on a monthly pro-rated basis, an amount up to 50% of the target fee." Section G(p)[1] indicates that partial underwriting fees will be paid in accordance with Section H. Does the contractor invoice for this monthly? If so, what are the payment terms? If not, does TMA automatically remit and what are the payment terms? (Received 16 August 2002)

RESPONSE: Yes, the contractor invoices for all payments. As stated in H-2, the contractor may do so on a monthly basis. This partial interim payment of the underwriting fee is considered a non-cost reimbursement item, so in accordance with G-3.a.(3)a., this payment is not subject to the Prompt Payment clause. Generally speaking, TMA attempts to make payments in 30 days, but this is not guaranteed.

72. Section I – We would like the Government to consider adding FAR 52.244-6 Subcontracts for Commercial Items and Commercial Components to Section I. This would ease the flow down requirements placed on commercial businesses used for the purchasing of commercial items in the daily business of the contractor. (Received 16 August 2002)

RESPONSE: This is not a commercial item requirement, therefore, the clauses pertaining to commercial items are not a part of this solicitation.

73. Section L.12.f.(4) - Page 89 indicates: Offerors shall propose a firm-fixed-price for each option period for the Operation of TRICARE Service Centers (TSCs). This price will include all costs uniquely associated with the on-site operation of all TSCs for the contract region and any satellite TSCs established off post due to inadequate space on post. Specifically, the price will only include the cost of staff, equipment, and services required to accomplish those functions required in the TRICARE Operations Manual, Chapter 12, Section 3." We assume that the following of the contractors Disclosure Statement and Cost Accounting Standards by pricing this out with direct labor, other direct costs, overhead, general and administrative costs, and profit would be an appropriate costing methodology as required in Section K of this RFP. Please confirm. (Received 16 August 2002)

RESPONSE: The assumption is correct. Fully burdened costs consistent with the offeror's disclosed accounting practices should be proposed along with the applicable profit to calculate the total price for the TSC operation. This would include any indirect costs, general & administrative costs, facilities capital cost of money, etc.

74. Reference H-1 b (4)(b). Please verify that in amount (1), the target fee remains a positive number, and only the second part of the amount (20% of the difference between the target cost and the actual cost) is negative. Also, please verify that "greater of" does not mean the larger absolute value.
(Received 16 August 2002)

RESPONSE: The questioner is correct in each case. In the amount (1) cited, the target fee is a positive number, the 20% contractor share in the second part of the amount is negative, and the "greater of" does not mean the larger absolute value.

75. Reference H-1 b (2)(b&c). These two sections appear to conflict regarding the setting of the retroactive target cost. In (b), it is said that the new target will be based on the prior year's target cost, while in (c), it appears that the new target is based upon actual healthcare costs from the prior year. Please clarify.
(Received 16 August 2002)

RESPONSE: Sub-paragraph (b) describes the "estimated target cost" that will be used for purposes of exercising the option period, in the event the target cost is not negotiated by 30 days before the option period. In this case, however, this "estimated target cost" is only an interim value for purposes of exercising the option period. Then, this interim value will be replaced after the new option period is completed, using the retroactive formula described in sub-paragraph (c). The retroactive formula sets the target cost as the product of the actual underwritten CHAMPUS health care costs in the region in the previous option period (e.g., to set the OP 3 target the previous year would mean the actual costs in OP 2) trended by the national percentage change in underwritten CHAMPUS health care costs from the previous option period to the current option period (e.g., to set the OP 3 target, the trend would be the percentage change in national underwritten CHAMPUS costs from OP 2 to OP 3). Thus, it is this retroactive formula which ultimately sets the target cost in the event negotiations do not achieve an agreed upon target cost before the option period is exercised. Below is an example of the fall-back formula approach.

Hypothetical Example of Retroactive Calculation of

Target Healthcare Cost for OP 3,

if Prospective Negotiation Fails to Produce an Agreed-Upon Target

Actual Regional Cost in OP 2	Actual National CHAMPUS Cost for Underwritten Care			Target Cost in Region for OP 3
	OP 2	OP 3	% Trend	
$1,000M	$3,200 M	$3,520 M	10%	$1,000M x 1.1 = $1,100M

76. Reference H-1 b (2)(c). Please give the mathematical derivation of the "national trend factor for underwritten CHAMPUS healthcare costs."
(Received 16 August 2002)

RESPONSE: Assume, for example, that the retroactive formula is being used to set the target cost retroactively for OP 3 of the West contract, and that OP 3 of the West contract covers April 2006 – March 2007. The national trend factor would be equal to the actual underwritten CHAMPUS costs in all three contract regions for April 2006 – March 2007 divided by the actual underwritten CHAMPUS costs in all three contract regions for April 2005 – March 2006. The actual underwritten CHAMPUS costs are defined as in Section H (e.g., measured from accepted TEDs, less unallowable costs determined by audits, estimated to completion, including resource sharing costs, etc.). Thus, on an incurred basis, if the actual national underwritten CHAMPUS costs were hypothetically $3.52 billion for April 2006 – March 2007, and the actual national costs incurred for April 2005 – March 2006 1 were hypothetically $3.20 billion, then the national trend factor for setting the West contract's OP 3 target if the formula were triggered would be 1.10 (3.52 / 3.20).

77. Reference H-1 b (2), second occurrence. If the target cost is set retroactively, how is the target underwriting fee set? Does the answer vary before and after the retroactive value is calculated?

RESPONSE: If the target cost is set retroactively, the target underwriting fee defaults to the fixed dollar value initially proposed for that option period in Section B (i.e., the dollar amount established at contract award, except as modified for definitized health care change orders or other equitable adjustments). This value will be used as the target fee both before and after the retroactive formula result is calculated. To summarize, the target underwriting fee is a fixed dollar amount.

78. Section H - Are all resource sharing expenditures, including projects where the providers/staff are paid on an hourly basis included in the cost reports and HCSR data tapes? If not, please provide expenditures by MTF? (Received 16 August 2002)

RESPONSE: The government does not believe that the data tapes and cost reports contain all information related to hourly paid Resource Sharing Staff. The available data was provided in Amendment 2.

79. August 2002 Operations Manual – Chapter 15 Section 3, paragraph 8.0 - Resource Sharing – One of the reporting requirements in this paragraph states "The number of outpatient visits and/or admissions "credited" to each agreement to meet the annual adjustment requirements." Please indicate what the annual adjustment requirements are as we don't believe there is a Bid Price Adjustment in the RFP. (Received 16 August 2002)

RESPONSE: Disregard the referenced provision; it will be deleted at a future date.

80. Please describe how the written proposal submission of Performance Standards will be evaluated. (Received 16 August 2002)

RESPONSE: Performance standards represent the product the offer is selling to the Government. We will evaluate the product as part of the technical evaluation of the offeror's ability to deliver the contract objectives and the proposal risk associated with the offer.

81. C.7.21.15 - Currently each region processes their own CHCBP claims. The assumption is being made that this will end and that any claims received in another region will be transferred to the holder of the South Region contract. Is that correct? (Received 16 August 2002)

RESPONSE: Yes

82. General – Please provide the enrollment revenue received for the latest three years by Region. Please list the dates the information applies to. (Received 19 August 2002)

RESPONSE: The requested information is proprietary and not releasable.

83. Section L-14 Resource Sharing – This section states "The expected administrative costs of resource sharing shall be included by the offeror in preparing its administrative price." We assume that these administrative costs would include the cost of performing the financial analysis worksheets and the cost of performing the resource sharing reporting as required in the Operations Manual and not the subcontractor administrative costs associated with the administration of projects such as management, recruiting, credentialing, claims generation, administrative support, etc. These costs are normally factored in as costs with each project as is the case with any commercial products. Additionally, Prime contractors may contract with different subcontractors on a project by project basis. Please clarify. (Received 19 August 2002)

RESPONSE: You are correct. Allowable administrative costs associated with each agreement shall be included in the agreement and not the overall fixed administrative price.

84. General - Currently, resource sharing providers are reimbursed under various methods. These methods include both those amounts billed on a HCFA 1500 and certain projects that are billed and paid on an hourly/salary basis. First, which of these costs are included in the data tapes supplied by the government?

RESPONSE: The data tapes include all costs for which a HCSR was submitted, including encounter records.

a. Second, if these costs continue, are they included as part of underwritten health care costs? If so, how will these be reported?

RESPONSE: Please see the RFP, Section H-4 for the requirements concerning underwritten health care costs and resource sharing.

b. Under the hourly project will a TED be produced? If so how? If not, how will the contractor be reimbursed? (Received 19 August 2002)

RESPONSE: If there is an hourly or monthly Resource Sharing project, payment and invoice process will be specified in the individual agreement. This is stated in the forthcoming amendment to Section G. If such a project involves professional services which can be reported using a CPT code, such workload may be captured through a TED. That also will be specified in the individual Resource Sharing agreement.

85. Section H-5d. This section states: "In reference to FAR 52.216-7(g), "audits", as used in this clause, includes audits on statistically valid samples. The audit results will be applied to the entire universe from which the sample was drawn to determine total unallowable costs. Overpayments made by the contractor, whether found in an audited sample or audit results applied to the entire universe from which the sample was drawn, are unallowable costs. The Contracting Officer will notify the contractor of intent to disallow costs in accordance with FAR52.242.1, Notice of Intent to Disallow Costs. Underpayments made by the contractor that are found in an audit are not used to offset overpayment adjustments." We have the following questions on this paragraph: (Received 19 August 2002)

a. What is the rationale for not offsetting overpayments with underpayments?

RESPONSE: It is the governments' goal to have all claims paid absolutely correctly. The government believes there are already adequate safeguards in place to ensure underpayments do not occur (i.e. beneficiary and provider complaints), therefore they are not included. The government must be assured that its' contractor is taking appropriate measures to prevent overpayments. In addition, the government does not want the contractor to have any incentive that might cause the rebuttal of preliminary audit results to be slanted in any way. The goal is to pay the correct amount every time, not on average.

b. Please provide an example of how TMA will calculate the amount of costs to disallow if, for example, overpayments are found to be 2% during an audit.

RESPONSE: The costs to be disallowed would be from costs from which the sample was selected. For example, 2% of reported healthcare costs would be disallowed before comparison against target cost. If the total reported health care costs on TED records were, for example, $100 million, a 2% overpayment error would result in $2 million being disallowed. The remaining $98 million would be compared against the target cost and used in determination of the fee earned.

c. Please also include how these disallowed costs will be applied against the contractor. Will the disallowed costs not be used in calculating the target fee or will they be offset against health care CLINs or administrative CLINs or will a lump sum payment from the contractor be expected?

RESPONSE: All erroneous claims in the sample would have to be corrected and resubmitted (over and under payments). Correction of TED records will result in corrected amount paid to contractor. The disallowed costs will not be included in the allowable costs used in calculating the target fee. The extrapolated amount due will be collected from the contractor as a deduction from the healthcare CLIN payments. In calculating the extrapolated amount due the government, the contracting officer will consider the net of both over and under payments. In no case shall the government pay any additional health care costs even if there is a net underpayment.

d. How often will these audits and calculations be performed? Please clarify. (Received 19 August 2002)

RESPONSE: Audits shall be conducted annually.

86. Section L.12.f.(2) – Page 89 indicates, "The Government has established an estimated level-of-effort for case management/disease management for each option period provided in Section B. The Contract Line Items (CLINS) associated with this effort are cost-reimbursable. The Government estimate includes the cost of medical management programs meeting the criteria specified in Section C-5.2.7. Offerors shall propose a fixed fee for each of the five options periods. The fee shall remain fixed regardless of the levels of expenditures experienced by the contractor for this effort and shall not exceed ten percent (10%) of the estimated contract cost for this CLIN in accordance with regulatory guidance." We have the following questions on this paragraph: (Received 19 August 2002)

a. Is the contractor free to input any unit price and amount on the 0x03AA CLIN series in Schedule B and not limited to the governments estimate?

RESPONSE: No. Offerors may not input any unit price and amount other than the Government provided estimate for the case management/disease management CLINS.

b. We assume that the estimated cost 0x03AA CLIN series would include direct costs plus the applicable overhead, G&A, and profit to match the requirements of Section K of the RFP and also to mirror the methodology in which the CLIN will be invoiced by the contractor. Please confirm.

RESPONSE: No. Offerors may not develop their own estimate. See answer to a. above.

c. Is the contractor prohibited from invoicing amounts over the contractor's estimated costs bid after the contract award is made?

RESPONSE: No. The Case Management/Disease Management CLINs are cost reimbursement. Section C details the requirements for proposing medical management programs for review and approval; to include individual program cost estimates. See the FAR and DFARS regarding administration of cost reimbursement contracts.

d. Is the fixed fee that can be bid limited to 10% of the contractor's price bid on the 0x03AA CLIN series or is it limited to 10% of the government's estimated cost contained in Schedule B?

RESPONSE: Offerors may not propose a fixed fee amount that exceeds 10% of the Government's estimated cost contained in Section B. Any amount proposed in excess of the 10% will be considered unreasonable and unallowable. See a. and b. above.

87. Section C-7.22 requires an Explanation of Benefit (EOBs) that describes the action taken on each claim be provided to each beneficiary and non-network provider. With consideration of the requirement in C-7.21.4 to provide an Internet Base Claims Processing System, is it acceptable to provide electronic EOBs in lieu of paper EOBs to beneficiaries and providers who prefer an electronic method of notification? (Received 20 August 2002)

RESPONSE: ***response revised 3 September 2002***

Offerors may propose any method of fulfilling the requirement. All EOBs submitted to providers must be data compliant with the Transaction and Code Set Rule of HIPAA.

88. Your response to Question #17, which asks for the zip codes for the new regions as referenced as included in Section J-4, Document XX of the RFP directs the reader to L-12f(4)(b). This section requires a payment of $3,000 for this information. Is there a way to obtain these zip codes at no charge since the zip codes for the new regions do not appear to align exactly with the old regions?
(Received 20 August 2002)

RESPONSE: No, this information is only available as specified. However, the new regions combine existing regions without boundary changes.

89. CLINs 0001, 0002, 0003, 0101, 0102, 0601, 0602, 0603, 0604, 1101, 1102, 1103 and 1104 each require pricing for phase-in activities associated with a specific period of time for a geographic portion of the each new contract. Section F.5 (page 37 – 39) describes several start-up related deliverables and performance requirements to be completed relative to the date of Contract Award rather than the date associated with the start of transition for each geographic area. Please clarify how the offeror is to propose costs for activities associated with fulfilling the requirements specified in Section F.5 that precede the date parameters associated with CLINs 0001, 0002, 0003, 0101, 0102, 0601, 0602, 0603, 0604, 1101, 1102, 1103 and 1104.

RESPONSE: The effort associated with the deliverable items in Section F.5 should be priced in the applicable CLINs in accordance with the delivery schedule. For an item scheduled to be delivered during the phase-in period, the costs should be reflected in the price for that CLIN. For an item scheduled to be delivered during Option Period I, the costs should be reflected in the applicable transition-in CLIN price.

90. CLINs 0108, 0206, 0306, 0406, 0506, 0611, 0707, 0807, 0907, 1007, 1110, 1206, 1306, 1406 and 1506 each require pricing for transition-out activities. Section L.12.(4)(i)(6) (page 90) states "Offerors shall propose a firm-fixed-price for each option period for transition-out activities. This price will include all costs associated with transitioning to a follow-on contract." Section F.5(d) (pages 39 – 40) presents several transition-out related deliverables and performance requirements to be completed relative to the date of successor contract award or start of health care delivery. The solicitation neglects to specify the amount of time between successor contract award and the start of health care delivery. Please clarify the assumptions the offeror is to use for pricing activities that occur between successor contract award and the start of health care delivery.

RESPONSE:

91. RFP Section C-7.1.16 page 26, Second sentence of the section states: "In urgent/emergent situations, a preliminary report of a specialty consultations shall be conveyed to the beneficiary's primary care manager within one hour by telephone, fax, or other means with a formal written report provided within the standard." Considering that many, if not most, urgent/emergent situations occur during non-provider office hours, will the government consider restating this requirement to a 24

hour period? Please provide your rationale for the one hour preliminary report requirement.

RESPONSE: ***revised 20 September 2002***

Please see the future amendments. We have listened to industry and in an amendment we will change the 1 hour preliminary reporting requirement for preliminary referral/consultation reports to being required within 24 hours unless best medical practices require a quicker response time.

92. RFP Section C-7.21.18 page 30 - Last sentence states "CHAMPUS Maximum Allowable Cost". Should this state "CHAMPUS Maximum Allowable Charge"?

RESPONSE: Yes; revised in Amendment 0001

93. Section L-10.c, page 80 states "Offerors shall submit their anticipated organization structure fifteen calendar days prior to the submission of their proposals. This document must include the prime contractor and major first tier subcontractors. The organization structure shall include addresses and telephone numbers." This requirement is not among the documents listed in L.12.c, page 82. Should offerors submit their anticipated organization structure 15 days prior to submission on a CD-ROM? What level or organization detail is required for the offeror's and proposed subcontractor organizations?

RESPONSE: A Word document attached to an email to the Contracting Officer listing the prime contractor and major first tier subcontractors to include the addresses and telephone numbers each is sufficient.

94. RFP Section L-12.f (2) Past Performance Information, page 87:
Subsection (b) states: The Government will only consider experience gained within the last three years" We assume that, for the purposes of Past Performance Information, this statement refers to information dating back to 10/1/99 which is a date 3 years prior to the schedule for submission of the Past Performance volume. Is this correct?

RESPONSE: An amendment will further clarify that the last 3 years is as of 60 days prior to the proposal submission date.

a. Subsection (b) states: " The information submitted shall include the following, at a minimum" "supporting documentation". We assume that this information **is not** included in the 25 page count. Is this correct? We assume that this information can include reports. Is this correct?

RESPONSE: The requirement to submit the supporting documentation with the narrative in Section L-12f.(2)(b) was removed in amendment 0001.

b. Subsection (d) states: "The offeror shall provide a brief discussion…"
We assume that this discussion **is not** included in the page count since these accounts may not be those referenced in the narrative. Is this correct?
Is there an associated page limit assumption that scope of work, successes and challenges need to be discussed? Please clarify the RFP Past Performance submittal requirements.

RESPONSE: Section L-12f(2)(d) brief discussion is not included in the page count. While there is no page limit, the operative word is "brief" and must not be a marketing or a sales presentation but should be factual.

c. Subsection (g)page 88, This section refers to "Attachment L-4". We assume the government meant Attachment L-**5**. Is this correct? Also in Subsection (g), This section refers to "…within the 36 months preceding the submission of the proposal." We assume that, for the Purposes of Past Performance Information, this is back to 10/1/99. This is correct?

RESPONSE: The reference should be Attachment L-5. This will be corrected.

d. Subsection (h) page 88, We assume the government intended to reference Attachment L-6 here. Is this correct? We assume key personnel information is excluded from the 25 page count. Is this correct?

RESPONSE: Key personnel information shall be submitted according to the format of Attachment L-6. This information is excluded from the 25 page count.

e. Subsection (i) page 88 states "The offeror shall provide copies of final reports and/or findings issued to any subcontractor….". We assume, given Section M indications, that the government intended this to include the prime contractor and subcontractors. Is this correct? We assume that, given the copies of the findings and the explanation required, that this information **is not** included in the 25 page limit? Is this correct? We assume that, for the purposes of Past Performance Information, that "two years prior to the submission" means findings issued back to 10/1/00. Is this correct?

RESPONSE: Include both prime and subcontractor reports which are is excluded from the 25 page limit. The complete phrase is "two years prior to the submission of the past performance information" with which the proposal submission date of November 1, 2002, would be reports issued two years prior to October 2, 2002.

95. Section L-12.f. page 87, Please confirm that the SF 33 does not need to be submitted with the Past Performance information.

RESPONSE: Paragraph L.12.f.(2)(a) does not mention the Standard Form 33. The paragraph pertains only to past performance information.

96. Section L.12.page 89 paragraph (2), immediately following paragraph L.12.f(4)i, (paragraph numbering sequence appears inconsistent) addresses the estimated level of effort for case management. RFP states: "The Government estimate includes the cost of medical management programs meeting the criteria specified in Section C-5.2.7" There is no section C-5.2.7 in the RFP.

RESPONSE: The reference in Section L should be C-7.7. Section L will be revised in a future amendment.

a. What then is the definition of Case Management/Disease Management and what are the criteria for what must be included in CLIN 0105?

The definition of case management is in the TOM, Appendix A; for disease management, see the definition of medical management in the TOM, Appendix A.

97. There appears to be a discrepancy between directives in the Operations Manual and Policy Manuals released August 2002. The issue concerns requirements for pre-authorization of outpatient mental health services and could be significant when determining operational requirements in the technical proposal. Policy Manual-Chapter 7, Section 3.13-IIC-pg1-states the contractor shall pre-authorize all outpatient psychotherapy beyond the eight visit in an enrollment period. (This has been the instruction that mental health has operated under the current contract period).
Operations Manual – Chapter 7, Section 2.0 and 2.0-Preauthorizations-pg 1
The required outpatient services will be pre-authorized: Adjunctive Dental- is the only service listed.
Outpatient mental health is not listed under this category. The only place mental health services are listed as requiring preauthorization is under inpatient admissions. Will the Government please clarify?

RESPONSE: The discrepancy will be corrected in an amendment. The requirement to preauthorize outpatient mental health care will be deleted.

98. TRICARE Operations Manual; Chapter 15, Section 3, 14.0, page 8, requires a monthly report to the Regional Office and the Contracting Officer on Customer Satisfaction. "The Customer Satisfaction Report shall include:

- The contractor's measurement of satisfaction, by category, to include active duty personnel, dependents of active duty, retirees and other eligible beneficiaries under age 65;
- Network providers;
- Non-network providers;
- MTF providers; and
- MTF Commanders"

Some of the categories mentioned, such as Non-network providers may have little or no contact with the contractor on a monthly basis. TOM Chapter 12 prohibits the contractor from conducting surveys, Section 3, 3.0. This may make the subject report statistically invalid based upon the scarcity of encounter data.
Would the government consider changing this requirement to a quarterly report, which would give the contractor the benefit of the surveys used for the quarterly award fee board? If not, could the government please expound on the type of data fields they would like to see by these categories on a monthly basis?

RESPONSE: The requirement for a monthly report will not change. The Government will not define the data fields and expects the contractor to exercise a "best practice" approach to determining customer satisfaction as it delivers best value health care.

99. In Section B, claim volume quantities are provided for pricing each CLIN. Please provide your methodology for calculating the estimated quantities contained on this schedule for all periods of performance. Please also provide the estimated number of claims by month for each region during the first option period in order to provide an accounting of these claim volumes during the staggered transition schedule. Current volumes in all contracts are <u>much less</u> when both pharmacy and TFL volumes are extracted.

RESPONSE:

100. In Section B, claim volume quantities for electronic submissions are provided for pricing each CLIN. The RFP split between electronic and paper is 85/15. Actual experience in all contracts when pharmacy and TFL are extracted is about 20/80. Please provide your methodology for estimating the electronic claim volume. In addition, please provide the current percentage of network versus non-network providers as well as the associated claim volume for all existing MCS contracts.

RESPONSE: Consideration was given to the effect of requiring all network providers to submit claims electronically and that the HIPAA Transaction and Code rule will be in effect upon start of health care delivery. The current percentage of network versus non-network providers and the associated claim volume for all existing MCS contracts can be determined from the data package.

101. Section C-7.1.10 requires all network providers to submit all claims electronically However, an exception to this requirement may be granted for a justified reason by the Regional Administrative Contracting Officer. Please explain what circumstances would constitute justification for not submitting claims electronically. Does the government anticipate that the exceptions will be granted on the basis of individual provider, provider type, claim type or some other classification? In the event that a network provider who has not been granted a waiver for the electronic filing requirement submits a hardcopy claim, how is the contractor to handle such claim? How does a network provider submit an electronic claim that requires a paper attachment?

RESPONSE: Justifications would be on a provider by provider request and would have to demonstrate extreme necessity for retention of the provider in the network. The Government expects the contractor to manage their network providers in a manner the fulfills the MCSCs contractual obligation. We are not aware of any remaining Government required claim attachments.

102. Section C, C-7.1.14 states that the contractor shall verify all providers "authorized" status through the TRICARE Management Activity centralized TRICARE Encounter Provider Record (TEPRV). Where may we obtain more information on the TEPRV system? Is there a requirement to read and validate provider information submitted on a claim against this file during claims adjudication? Is the contractor required to interface electronically with the TEPRV database? If so, will this be on-line, real-time access available 7 days a week, 24 hours a day?

RESPONSE: The answers to your questions are contained in the TRICARE Systems Manual (TSM) 7910.1 M, August 1, 2002.

103. Section C-7.5, page 26, states that the MTF will be sending referral information to the contractor in a HIPAA compliant manner. The TRICARE Operations Manual (August 1, 2002), Chapter 1, Section 8, item 1.3, Interface Meetings, references a MHS Referrals and Authorization System. Please describe the business function of this system and the expectations of the contractor related to this system. Will the contractor be required to only accept data from this system for MTF reliants in the HIPAA-compliant 278 format, or will the contractor be required to load referral and authorization data into this system and interface with this system during adjudication? If so, will this be on-line real time access available 7 days a week, 24 hours a day?

RESPONSE: The function of this system is for the MTFs to send and receive referrals. The contractor is required to transmit referrals to the MTF for a determination of availability in accordance with the "first right of refusal" provision. When an MTF refers a patient to a civilian source of care, the MTF will send the 278 transaction to the contractor to load in the contractor's system(s).

104. Section C-7.21 requires the claim processing system to be a single database and HIPAA compliant. Does this mean a single claims processing system or can multiple processing systems be used provided a single database of all processed claims is produced?

RESPONSE: The requirement is for a single system. However, this single system may be operated from multiple locations.

105. Section C-7.23, page 30, requires the contractor to interface with the TRICARE Encounter Data (TED) system. Will the interface with this system be tested in the Benchmark Test? If so, would the first test of this interface be expected to occur 6 months prior to Health Care Delivery (page 40), or September 2003? Will the incoming contractor be required to convert existing HCSR data to TEDS?

RESPONSE: Please refer to the TRICARE Operations Manual, Chapter 1, Section 8 for a full description of the benchmark test and the timing of the test.

106. Section C-7.35 references "MHS Enterprise Architecture". The WEB site (hhtp://www.hirs.osd.mil/hdp.index.html) noted in the reference is not functional. Can the government provide the contractor with information on the requirements of the "MHS Enterprise Architecture"?

RESPONSE: The Government will obtain the architecture and provide it to all offerors who requested a data package.

107. Section C-7.36 requires contractors to comply with the Personnel Security program, stating that all contractor employees with access to Government Systems be designated ADP level I, II or III and complete the appropriate background checks as described in Section J, Attachment 5. Please verify whether the requirement for Personnel Security classification with background checks applies to contractor employees with read only access to government systems via contractor systems such as DEERS, CDCF and TEDs.

RESPONSE: Yes, the individual with read only access would require the appropriate level of security checks.

108. Section C-7.44 requires the contractor to implement and operate all provisions of this contract in a TRICARE contract region not initially awarded to the contractor within 60-days of receiving notice from the Contracting Officer. We do not fully understand this requirement and request additional information on the requirements of the contractor, including an example(s) of circumstances when this provision would be invoked.

RESPONSE: C-7.44 was removed in Amendment 0001.

109. Please reference Section H.11.a.(2).(b), page 56. We believe there is a word omission in the last paragraph on page 56. When discussing error determination

rebuttals, the government explains what documentation is needed and then states, "Absent any of this documentation the payment error will be removed." We presume that in the absence of such documentation, the government means that the error will not be removed. Please clarify.

RESPONSE: This paragraph will be deleted in a future amendment.

110. Section K.11 includes FAR 52.230-1 Cost Accounting Standards Notices and Certifications. However, Cost Accounting Standards per 48 CFR 9903.201-1 contains 15 categories of contracts that are exempt from all CAS requirements. Specifically, "Firm fixed price contract or subcontract awarded on the basis of adequate price competition without submission of cost or pricing data" is listed as one of these categories. As a result, the contract to be awarded is exempt from all CAS requirements. Does the Government concur with this conclusion?

RESPONSE: No. The contracts resulting from this RFP are not firm-fixed-price contracts; therefore, they are not exempt from CAS coverage.

111. The RFP contains FAR 52.215-20 Requirements for Cost or Pricing Data or Information Other than Cost or Pricing Data. However, the text of the provision contained in the RFP deals only with the submission of Cost or Pricing Data. Cost or Pricing Data is not being submitted and therefore the text of the provision for FAR 52.215-20 should not address Cost or Pricing Data. This is a competitive acquisition with the offeror providing Information Other than Cost or Pricing Data in the form of cost build ups to support the proposed rates (per Section L.12). The offeror suggests that "Alternative 4" of the FAR clause 52.215-20 should have been used to replace the text of the basic provision. As a result, the entire text as contained in Section L.7 should be changed to read, "Submission of cost or pricing data is not required. Reference Section L.12 Proposal Preparation for the information that is required." Does the Government concur with this position and will this clause be changed?

RESPONSE: The clause will not be changed. If only one offer is received for a contract region, this clause is necessary if the contracting officer requires cost or pricing data to determine price reasonableness. Note that this clause is in Section L. Section L is not part of the awarded contract.

112. The RFP contains FAR clauses that deal with the submission of Cost or Pricing Data, which are typically only included in solicitations when there is not a competitive acquisition. Specifically, the RFP contains FAR 52.215-10 Price Reduction for Defective Cost or Pricing Data, 52.215-12 Subcontractor Cost or Pricing Data, which the offeror suggests should not be applicable to this contract because this is a competitive source selection (per Section M.3). Since the submission of Cost and Pricing Data is not required then the stated FAR clauses should be removed from the contract. Does the Government concur with this position and will these clauses be removed from the contract?

RESPONSE: Please see answers 111 and 348.

113. TRICARE Operations Manual, Chapter 12, Section 7.3.2 (August 1, 2002) states "the contractor shall transfer out of jurisdiction calls requiring the assistance of another contractor." Is the intent of the government for the contractor to not refer the caller to the appropriate contractor but for the contractor's customer

service representative to place an outgoing call to connect the caller to the correct contractor?

RESPONSE: The Government's intent throughout this contract is to provide exceptional customer service. This includes transferring calls rather than providing telephone numbers and hanging up.

114. L-12.f.(2)(b) – Does the 25 page limit apply for the total contract or do each of the first tier subcontractors have 25 pages to present a past performance narrative?

RESPONSE: The 25 page limit applies to Sections L-12.f.(2)(b) and L-12.f.(2)(c).

115. L-12.f.(3) – Does the requirement to submit financial information apply to first tier subcontractors?

RESPONSE: No

116. L-12.f.(2)(h) – This requirement says that the government may contact all references on the form. There are no references requested on the form. How many references are desired?

RESPONSE: ***Revised 3 September 2002***

The reference is to forms and refers to all forms provided, not just Attachment L-6. No references are required on Attachment L-6 but may be provided.

117. C-7.1.1. – Will the contractor's NCQA accreditation suffice to meet the requirement to have the network accredited by a nationally recognized accrediting organization?

RESPONSE: NCQA is one nationally recognized accrediting body.

118. C-7.1.16. – Are behavioral health providers subject to the requirement to submit consultation reports to the beneficiary's primary care manager?

RESPONSE: Yes.

119. C-7.2. – Would a behavioral health subcontractor be expected to audit 2% of these referrals, or would the prime contractor be responsible for determining whether and how to include them?

RESPONSE: MTF PCMs will make referrals when medically necessary and appropriate. The Audit requirements apply to the contract, in total. The Government will hold the prime contractor liable for accomplishing all required tasks. How subcontractual agreement are created and what is included is a matter between the prime contractor and their subs.

120. C-7.3. and C-7.4. – Section C-7.3. addresses an administrative coverage review that does not encompass preauthorization. Section C-7.4. addresses a medical necessity review for behavioral health care for beneficiaries who are **not** enrolled to an MTF. To what behavioral health services do these requirements apply. (Please reference the TRICARE Policy Manual, Chapter 1, Section 7.1.I. that indicates

that all behavioral health services for all beneficiaries are to be reviewed for medical necessity except the first eight outpatient psychotherapy sessions).

RESPONSE: Per 32 CFR 199, no payment may be made for services which are not medically necessary and appropriate. The Policy Manual does not eliminate this requirement.

121. C-7.3.3. – Which HEDIS measures are applicable to behavioral health services?

RESPONSE: ***Revised 26 September 2002***
RESPONSE: The HEDIS measures requirements will be deleted in a future amendment.

122. C-7.17. – Does the requirement to provide 10 person-hours per week to be used at the MTF commander's discretion apply exclusively to the prime?

RESPONSE: All requirements of this contract apply exclusively to the prime. The Government has no contractual relationship with any other party.

123. C-7.28. – Where will the TRICARE Regional Administrative CO's office will be located?

RESPONSE: The 3 Regional offices will be in San Antonio, TX, San Diego, CA and Washington, D.C.

124. CLIN 0101 States Option Period I is from 1 April 2004 until 31 March 2004. Please confirm that Option Period I is from 1 April 2004 until 31 March 2005.

RESPONSE: Confirmed; date was revised in Amendment 0001.

125. CLIN 1103 States the transition expires in Option Period I on 31 May 2004. By contrast, Section F, Deliveries or Performance, F.3.b.(3)(b) on page 37 states the transition expires in Option Period I on 31 March 2005. Please confirm that the transition expires in Option Period I on 31 May 2004.

RESPONSE: Confirmed; date was revised in Amendment 0001.

126. CLIN 1112AA The Amount column for this CLIN states "To Be Negotiated". The CLINs for the West and South Region Option Period I Target Underwritten Health Care Costs do not so state. Please confirm whether CLIN 1112AA will be negotiated.

RESPONSE: Confirmed. CLIN 1112AA will be revised in a future amendment.

127. C7.1 What criteria will the Government use to assess network stability?

RESPONSE: Evaluation criteria are not releasable

128. C.7.1.1. How will the Government enforce the requirement that the contractor acquire accreditation?

RESPONSE: We have many choices including, but not limited to, termination for default.

129. C.7.1.10. Will the Administrative Contracting Officer grant a blanket exception to allow the contractor to meet network adequacy and access standards?

RESPONSE: No, we fully expect to receive what we pay for.

130. C7.1.10. If a provider does not have the capability to submit electronic claims, how long does the provider have to get compliant and put whatever infrastructure (e.g., hardware, software, policies) is needed on their end?

RESPONSE: The requirement is for the prime contractor. How the prime elects to manage their subcontractors, the providers, will not be dictated by the Government. We will hold the prime responsible for fulfilling the contract requirements on the first day of health care delivery.

131. C7.1.10. How does the Government intend to enforce 100 percent participation for electronic claims submission? Will the Government create two categories of network provider: 1.those that can submit electronically and 2. those that do not have this capability?

RESPONSE: We will hold the prime contractor responsible. The Government will not create special provisions that allow contractors to avoid delivering the services required by the Government.

132. C7.1.10. Will the Administrative Contracting Officer grant a blanket exception or only on a case by case basis?

RESPONSE: Case-by-case

133. C7.1.11. Is the contractor responsible for encouraging the acute care medical/surgical hospitals in its network to become members of the National Disaster Medical System?

RESPONSE: Yes, this is listed as a "requirement."

134. C7.1.11. Does the contractor need to be able to report which of the acute care medical/surgical hospitals in its network are members of the National Disaster Medical System?

RESPONSE: This is beyond the scope of the requirement.

135. C7.1.12. May the contractor use education materials (e.g., direct mail, handouts, presentation, provider handbooks) it develops for providers in addition to those provided by the Marketing and Education contractor?

RESPONSE: No, MCSCs must work through the Marketing and Education contractor to obtain needed materials.

136. C7.1.13. Is there a specific point of contact at the VA Health Administration Center to whom the contractor should furnish its central address for delivery of marketing and educational materials?

RESPONSE: Yes. The name and address will be provided post award.

137. C7.1.13. Please clarify whether and when the DVA will provide the materials.

RESPONSE: The provision clearly states, "When the DVA provides the materials".

138. C7.1.15. Does this requirement pertain if the beneficiary chooses to use the Point of Service option for non-excluded services?

RESPONSE: Yes

139. C7.1.16. Does the requirement to provide a consultation report within five working days apply only to beneficiaries enrolled to MTF Primary Care Managers? Does the requirement apply only to beneficiaries enrolled in TRICARE Prime (both civilian and MTF)? Does the requirement apply to beneficiaries enrolled in TRICARE Plus?

RESPONSE: The requirement applies to all MHS beneficiaries.

140. C7.1.16. Does the requirement refer to care provided by non-network providers?

RESPONSE: No.

141. C7.1.16. Please define referral reports as used in relation to this requirement.

RESPONSE: A report of the clinical treatment provided and recommendations for further treatment.

142. C7.1.2. What responsibility will the contractor have regarding the requirement that MTFs refer their TRICARE Prime enrollees to network providers (except as stated) and that the Regional Director approve exceptions? Will the MTFs contact the Regional Director directly or through the contractor?

RESPONSE: ***Revised 9 September 2002***

These exceptions will be reported by the MTF Commander and will not involve the contractor.

143. C7.1.2. Expand on the statement that federal health care systems are excluded from this Government policy. Does this mean that MTFs can or should refer to these systems even though there may be other non-network providers available who may be more clinically or financially advantageous?

RESPONSE: The MTF can refer to other Federal Health Systems without regard to cost, network status, credentialling or any other factor.

144. C7.1.3. Does the requirement to include providers for the MHS Medicare population mean that the contractor network must contain specialists in geriatrics and other specialties likely to be used by the MHS Medicare population?

RESPONSE: Yes, this contract is to service the MHS population, in total.

145. C7.1.3. What level of interface will be required between the TDEFIC and the MCSC regarding provider data, network maintenance, and network education?

RESPONSE: Very little. TDEFIC will adjudicate claims based either Medicare's determination, the TEPRB, or through their own authorization activity. Network maintenance is the MCSC's sole responsibility, to include training on ALL aspects of TRICARE.

146. C7.1.3. Will the Government require the contractor to provide information on its network providers to the TRICARE Dual Eligible Fiscal Intermediary contractor? If so, what information does the TDEFIC require? If not, what is the purpose of requiring the contractor to build networks to ensure access standards are met for the MHS Medicare population?

RESPONSE: Please see the previous response. The purpose is to provide a very high level of service to all or our beneficiaries. It is critical that every interested bidder recognizes the responsibility the Department accepts for all of our beneficiaries and, in recognizing this fact, prepares to provide the required level of service, without hesitation.

147. C7.1.4. Is it the Government's intent to limit the contractor's response only to the agents listed in the requirement, or should the contractor provide this response to any agent of the Government?

RESPONSE: The requirement is to respond to Government agents. The positions listed are the most likely individuals to require the information.

148. C7.1.4. Please clarify how the contractor should inform the Government and who specifically the contractor should notify.

RESPONSE: The contractor shall notify the personnel specifically listed in this provision of inadequacies. The notification shall include the material required in the specification.

149. C7.1.4. Does the definition of network inadequacy include any single instance of a patient being unable to obtain an appointment within the distance or wait access standards? If the answer is yes, does the definition of network inadequacy also include an instance of patient's refusal to accept a network provider who can provide an appointment within access standards?

RESPONSE: Yes, the definition of network inadequacy includes any single instance of a patient being unable to obtain an appointment within the distance or wait access standards. It does not include an instance of a patient's refusal to accept a network provider who can provide an appointment within access standards.

150. C7.1.5. In light of the dynamic nature of MTF capabilities (most especially under mobilization or deployment contingencies), will the Government grant relief from office wait time and appointment wait time access standards in these situations?

RESPONSE: Absolutely Not.

151. C7.1.6. Would an incumbent MCS contractor who was a successful offeror under this solicitation need to amend existing TRICARE network provider agreements to include the VA provisions? Given declining reimbursement levels (in line with

Medicare) and growing provider dissatisfaction with TRICARE administrative requirements, is it in the best interest of the program to have to conduct a significant recontracting or amendment process in order to meet the RFP requirements?

RESPONSE: Yes. The second question concerns a policy issue and will not be addressed through this venue.

152. C7.1.6.1. Please clarify whether the contractor should ask all providers to accept CHAMPVA assignment or just the providers listed in the parenthetical statement?

RESPONSE: Just the providers listed in the parenthetical statement.

153. C7.1.6.1. Is the contractor responsible for reporting this information to the CHAMPVA? If so, how, to whom, and at what intervals should the contractor submit the information?

RESPONSE: The requirement is, "For any published network provider listing, the contractor shall indicate in a readily discernable manner which providers accept CHAMPVA assignment on claims." Since these listings are available to the general public, it is not necessary to provide the Veteran's Administration with special listings.

154. C7.1.7. Please clarify the ways in which the contractor is to ensure that access standards are met for Prime Service area beneficiaries?

RESPONSE: The way in which the contractor ensures access is the contractor's responsibility to propose.

155. C7.1.8. Does the contractor have to publish the National Guard/Reserve status of its network providers?

RESPONSE: No, however, the contractor must be able to provide this information to the Government, upon request.

156. C7.1.9.4. Reference CFR 199.17(q). It appears that, under this clause, an MTF Commander can invoke the "any qualified provider method." Is this correct? If so, how does this interact with the contractor's network? Can this override a contractor's network? How would the healthcare target cost be adjusted for such a decision?

RESPONSE: ***response revised 3 September 2002***

This section of the regulation was written to address implementation of TRICARE in locations where a Managed Care Support Contract was not yet in place, or where it was not possible to implement a contract. Since we were able to implement managed care support contracts across the country, the section was never needed. The TRICARE final rule in October 1995 was clarified in response to comments about the section:

"As provided in section 199.17(p)(7), there are several possible methods for establishing a civilian preferred provider network, including competitive acquisitions,

modification of and existing contract, or use of the "any qualified provider" approach described in section 199.17(q). The current method of choice in implementing TRICARE is the first approach: DoD plans to award several regional managed care support contracts in the next few years. The managed care support contractors will establish the civilian provider networks according to the requirements specified in the government's request for proposals (RFP) for each procurement; these RFP requirements will be consistent with the provisions of section 199.17(p). At this point, we do not anticipate any broad use of the "any qualified provider" approach; it could be used under special circumstances, however."
155. C7.1.9. For any of the MTFs in any of the Regions:

157. C.7.1.9. For any of the MTFs in any of the Regions

a. Is there any planned downsizing in services or personnel?

RESPONSE: TMA is not aware of any publicly announced downsizing in services or personnel; however, offerors must be aware that military troop movements are often times secret.

b. Are there any planned additions in services or personnel?

RESPONSE: TMA is not aware of any publicly announced additions in services or personnel; however, offerors must be aware that military troop movements are often times secret.

c. What are the current resource sharing and support projects (by number of personnel and expenditure)?

RESPONSE: All current Resource Sharing and Resource Support projects will terminate with the expiration of the current contracts. The Surgeon's General are evaluating these initiatives and, where appropriate, will replicate current services provided under existing Resource Sharing and Resource Support provisions via means other than the Managed Care Support Contracts. The data package available for purchase in support of this RFP contains the information currently publicly available on existing agreements.

d. What are planned and/or desired resource sharing projects?

RESPONSE: The Government has not established a list of planned or desired agreements. Rather, the requirement is for the contractor to address in the proposal the offeror's criteria for determining the appropriateness of a Government proposed agreement and the processes the contractor will employ to identify potential resource sharing opportunities (See Section L-12.e.(1)(a)[2]).

158. C7.1.9. Please provide a listing of the TRICARE special programs, as the term special can be interpreted in many ways and is not defined in the Operations Manual, Appendix A.

RESPONSE: These programs are all included in the TRICARE Operations and TRICARE Policy Manuals. An example is Program for Persons with Disabilities.

159. C7.1.9. Please specify the complement of services provided by each MTF in each region.

RESPONSE: Please refer to the data package for all available information.

160. C7.10 Would electronic notification meet the notification requirement?

RESPONSE: Please see Amendment 0001 for the revision to this requirement.

161. C7.10 May the contractor create the notification letter, or will the contractor use a standard letter from CHCS?

RESPONSE: Please see Amendment 0001 for the revision to this requirement.

162. C7.10 Should the contractor mail the letters using first-class postage or another level of postage?

RESPONSE: Please see Amendment 0001 for the revision to this requirement.

163. C.7.10 Can the contractor have access to DOES at all of the contractor's locations, including TRICARE Service Centers?

RESPONSE: No.

164. C.7.10 If DEERS is considered to be the enrollment system of record, what flexibility does the contractor have to interface real-time with DEERS? Will the Government allow the contractors to create a "real-time" 2-way standard interface to DEERS through a secure network for accurately handling enrollments, re-enrollments, disenrollments, and transfers in and out of the region?

RESPONSE: Please refer to the TRICARE Systems Manual, Chapter 3.

165. C.7.10 If CHCS system problems prevent the contractor from assigning a Primary Care Manager, what is the contractor's responsibility to complete the assignment?

RESPONSE: The requirement for the contractor to directly access CHCS to enter the MTF enrollee's PCM was deleted in Amendment 0001. The contractor will enter all enrollments into DEERS/DOES. If a network problem prohibits communication between DEERS and a CHCS system DEERS will collect the information until communications are restored. At that time, DEERS will retransmit the backlogged notifications in the order the transactions were processed.

166. C.7.10 If the contractor will not assign a PCM for TRICARE Plus enrollees, who will?

RESPONSE: Please see Amendment 0001 for revised requirements.

167. C.7.10 How will the contractor receive accurate lists of MTF PCM names, locations, and telephone numbers from which to create notification letters?

RESPONSE: DMDC/DEERS will issue the notification letters.

168. C.7.11. What Government systems are used in the enrollment process?

RESPONSE: Please refer to the TRICARE Systems Manual, Chapter 3.

169. C.7.11. Will the Government allow the contractor to have read-only access to DOES from multiple locations?

RESPONSE: No

170. C.7.11.Will the Government allow a two-way, real-time interface into the DEERS system for electronic enrollment, disenrollment, and changes in status?

RESPONSE: Please refer to the TRICARE Systems Manual, Chapter 3.

171. C.7.11. Does the contractor have to provide the forms to MTFs and the Regional Director, or will these DOD units have their own supply of forms?

RESPONSE: Your question is unclear. If you are referring to the enrollment and disenrollment forms, the Government will furnish all enrollment forms. Please see Attachments 2 and 3.

172. C.7.11.Will electronic signature on enrollment forms be allowed? What is the Government's definition of an electronic signature?

RESPONSE: TMA has not approved the use of electronic signatures on enrollment forms.

173. C.7.11.Will the Government provide the contractor with a form for enrollment in TRICARE Plus?

RESPONSE: The contractor will use the enrollment and disenrollment forms in Attachments 2 and 3.

174. C7.11. Does an enrollment form submitted at the TRICARE Service Center count as receipt by the contractor for the purposes of calculating enrollment processing cycle time? If so, then the contractor would need access to the government-furnished enrollment application at the TRICARE Service Centers to complete enrollments timely.

RESPONSE: Receiving an enrollment form at any contractor port of entry counts for the purposes of calculating enrollment processing cycle time. Contractors will use the Government forms as indicated in Attachments 2 and 3. Ready access to the forms is a contractor responsibility.

175. C.7.12.Will Military Treatment Facilities communicate enrollment capacity in the Collaborative Agreement? If not, how will Military Treatment Facilities communicate enrollment capacity to the contractor? How often will the Military Treatment Facilities update their capacities and communicate this information to the contractor?

RESPONSE: Please review the data package for historical information. The enrollment capacity of each MTF will be a part of the Memorandum of Understanding (MOU) reached with the MTF Commanders as further discussed in the TOM, Chapter

16. Updates are as necessary to ensure balance workloads between the MTF and the civilian network.Please review the data package for historical information. The enrollment capacity of each MTF will be a part of the Memorandum of Understanding (MOU) reached with the MTF Commanders as further discussed in the TOM, Chapter 16. Updates are as necessary to ensure balance workloads between the MTF and the civilian network.

176. C.7.12. Should the contractor adhere to the 30 minute drive time access standard in determining whether to enroll all beneficiaries to the MTF until capacity is reached? How should the contractor measure the 30 minute drive time?

RESPONSE: Yes. The Government will not instruct the contractor on its procedures of how to measure the drive time.

177. C.7.12.1 Is the contractor responsible for receiving exception requests and forwarding them to the MTF commander? How will the MTF commander notify the contractor of a decision to waive the requirement?

RESPONSE: If received by the beneficiary, the contractor shall forward the request to the MTF Command according to the procedures established in the MOU.

178. C.7.12.1 How quickly will MTF Commanders and the Regional Director decide whether to approve exceptions to MTF enrollment?

RESPONSE: That will be covered in the MOUs. Please see the TOM, Chapter 16, Addendum A.

179. C.7.14 How will the contractor initiate the allotment from retirement pay option if an enrollee chooses it?

RESPONSE: The beneficiary initiates the allotment.

180. C.7.16. What scope of services must the contractor provide on site at a TSC?

RESPONSE: Please refer to the TOM, the relevant sections of Chapter 12 and the RFP, Sections C-7. 8., C-7.10, C-7.16, and other relevant sections of the RFP.

181. C.7.16. What are those customer service activities that the contractor must provide offsite? How does the Government define highest service levels?

RESPONSE: After reviewing the sections referenced in question 178, the contractor shall make its own determination of how to best meet the requirements and the objective of maintaining beneficiary satisfaction at the highest.

182. C.7.16. Do the offsite activities have to occur within the catchment area? Do they have to include walk-in service?

RESPONSE: The requirement states that off-sites must be convenient to the beneficiaries. The contractor shall make its own determination of how to best meet the requirements and the objective of maintaining beneficiary satisfaction at the highest level.

183. C.7.16. Will the Marketing and Education contractor ship directly to the TSCs?

If so, how often

RESPONSE: No. Please refer to the draft Marketing and Education Section C published on the TMA web site:
http://www.tricare.osd.mil/pmo/t-nex/marketing_education/

184. C.7.16. Will beneficiaries call the Marketing and Education contractor or the Managed Care Support contractor to request materials to be mailed to them?

RESPONSE: Beneficiaries will call only the MCSCs for information.

185. C.7.16. If access to TRICARE Service Center physical space is limited or terminated for the reasons stated, does the contractor need to provide the TRICARE Service Center services in the catchment area? If yes, does the contractor need to maintain an off-base facility that it can activate during periods of limited or terminated access?

RESPONSE: As stated in the RFP: "The contractor shall establish a customer service presence for all MHS eligible beneficiaries at each MTF, Prime service area, and BRAC site, either within the MTF, on the base, or if a BRAC site, at a location convenient to beneficiaries." The contractor shall make its own determination of how to best meet the requirements and the objective of maintaining beneficiary satisfaction at the highest level.

186. C.7.16. What TRICARE Service Center activities must the contractor conduct during such contingency periods? Does the contractor have to provide walk in service capability during such contingency periods?

RESPONSE: The contractor must maintain the same level of services during contingency periods as if no contingency existed and continue to meet the standards required by the contract.

187. C.7.16. What does the Government consider to be a customer service presence?

RESPONSE: The contractor shall have contractor staff physically located where TSCs are required.

188. C.7.17. May the MTF Commander use the 10 person-hours per week for non-TRICARE related services, at his or her discretion?

RESPONSE: No.

189. C.7.17.Is the requirement 10 person-hours per TRICARE Service Center? Is the Regional Director entitled to 10 person-hours per week for all noncatchment areas? For the purposes of this requirement, are non-catchment areas locations where TRICARE Prime is not offered, or are non-catchment areas locations where there is no MTF?

RESPONSE: It is 10 person hours at each MTF Commander's direction. The Regional Director will provide input to each MTF Commander as to the needs of the non-catchment area (no MTF) beneficiaries.

190. C.7.18 Does the contractor need to provide automated Health Care Finder Services accessible via the Internet or other automated means? Does the Government consider these Services to be part of the customer service that the contractor will provide, and thus subject to customer service performance standards?

RESPONSE: Please refer to the RFP, Section C-7.6. The standards of this contract apply to all venues of customer service.

191. C.7.2. Will the Military Treatment Facilities provide evidence of the receipt of the reports to the contractor?

RESPONSE: The acknowledgement of receipt of the consultation or referral reports are to be addressed in the MOU.

192. C.7.2. The audit must determine whether the provider returned all required information within the standard. What information does the Government require?

RESPONSE: The information necessary for the primary care manager to make an informed decision on the status of the beneficiaries care and health.

193. C.7.2. Please clarify the scope of the corrective action plan that the contractor develops when the audit reveals failure to respond in more than two percent of the sample? Does the plan need to address all referrals or just those over the two percent? How is the contractor to determine which referrals fall into the under two percent portion or the over two percent portion?

RESPONSE: The corrective action plan must address the how the contractor will ensure that all referral reports containing the necessary information are received at the MTF within the standard set forth by Section C-7.1.16.

194. C.7.21.What does the Government mean by a single database?

RESPONSE: The requirement is for a single system. However, this single system may be operated from multiple locations.

195. C.7.21.1. What does the phrase "claims/encounters (including adjustments)" mean?

RESPONSE: Please see the TOM, Appendix A for the definition of claims and adjustments. Encounters refer to services rendered where no claim forms (hard copy or electronic) are generated but must be reported as required by the claim definition.

196. C.7.21.15 Do the North or West contractors process authorizations for beneficiaries enrolled in the Continuing Health Care Benefit Program who reside in the North or West regions? Do the North or West contractors include Continuing Health Care Benefit Program enrollees living in the North or West regions in their medical management, clinical management, or disease management.

RESPONSE: All activities (e.g. claims processing, enrollments, customer service) for CHCBP enrollees will be conducted by the South Contractor.

197. C.7.21.18 In the example given, who is liable for any amount above the appropriate copayment?

RESPONSE: The contractor is liable.

198. C.7.21.18 If an MTF refers its Prime enrollee to a non-network provider who does not accept assignment (and thus may charge up to 15 percent over the allowable amount), may the contractor report the health care costs paid in excess of CMAC, DRG, or prevailing charges for the purpose of actual costs reported for health care fee determination?

RESPONSE: No

199. C.7.21.2. What is the extent of the "program administration" and "incurred cost" data that the contractor must make available to the Government?

RESPONSE: Examples of program administration would be the organizational structure and the contractors' internal policies, procedures, and standards for meeting the requirements of the contract. Incurred cost data is all health care costs.

200. C.7.21.2. Please specify how the Government wants to access the contractor's full set of TRICARE data. Please specify whether the contractor needs to analyze any of the data, or whether the Government only wants access to the raw data.

RESPONSE: Access may be obtained through a secure Internet portal, government data lines (NIPRNET See the TSM, Chapter 1), or other avenues that will be addressed during the transition. The contractor will not be asked to analyze any of the data that is not otherwise already required by the contract to include the manuals.

201. C.7.23 How quickly will the Government process TEDs?

RESPONSE: Generally, initial processing of TEDs is nightly. Please refer to the TOM, Chapter 3 and the TSM, Chapter 2 for complete details.

202. C.7.23.1 Can the contractor use the Medicare Common Working File provider identification number?

RESPONSE: No

203. C.7.23.1 Will the Government adopt a national TRICARE provider number?

RESPONSE: When CMS issues the final rule adopting the National Provider Identifier (NPI) the TRICARE program will be required to utilize the NPI.

204. C.7.24.1 Will the Government reimburse travel costs associated with the contractor's participation in the round table meetings as Contracting Officer directed travel?

RESPONSE: The Government will not reimburse any costs associated with this travel. These costs are to be included in the appropriate CLIN.

205. C.7.24.1 Please clarify the estimated time requirements for attending these

meetings. Where is the anticipated meeting place for these sessions?

RESPONSE: There are no estimated time requirements for attending these meetings and would be based on the agenda. It is anticipated that the session would last no more than 5 workdays. Meeting places would vary but possible locations would be TMA and the Regional Offices.

206. C.7.26 Will the Government establish a presence at each of the Prime contractor's locations? If not, at which location? Is it the same location as the senior executive's referenced in C-7.28.?

RESPONSE: That is the Government's intent. It is not the same location as Section C-7.28; the government presence is at the Prime and each major subcontractor's location.

207. C.7.26 Does the Government intend to establish a presence at each "major subcontractor" location or each "major location" of subcontractors? How does the Government define either? Who decides whether to designate a subcontractor or a location as major?

RESPONSE: See the response to question 204.

208. C.7.27. Does the Government intend to have a full time representative on site at each of the first tier subcontractors' locations? How will the Government representative interact with subcontractor personnel? If the Government representative is not on site on a full time basis, how will the Prime contractor be informed of the Government representative's intent to visit a subcontractor? Will the Government commit to not interacting with subcontractors unless a representative of the Prime contractor is notified and allowed to be present?

RESPONSE: ***revised 13 September 2002***

See answer to number 209 below for the answer to the first question. Government representatives assigned on-site as their duty station will be designated as a Alternate Contracting Officer Representative (COR) as described in DFARS 201.602-2. The contractor will be provided a copy of the ACOR's designation letter, which includes responsibilities. The Government does not intend to visit a subcontractor without informing the Prime, which is not to be considered asking permission. The Prime contractor has the opportunity to be present, and the Government takes no exception to the presence, but that is the Prime's responsibility to ensure their own presence during interaction at a subcontractor's facility.

209. C.7.27. If the Government assigns more than one Government representative at a Prime or subcontractor location, does the contractor need to provide more than one fully-functional office and attendant equipment? If the answer is yes, when will the Government disclose the number of representatives to allow offerors to price and plan for the office space and equipment?

RESPONSE: ***revised 13 September 2002***

This paragraph states, "The prime contractor and each first tier subcontractor shall provide full-time office space and support services….". As stated in paragraph C-7.26, the Government intends to establish a presence. The Government cannot

commit before award to how this will be accomplished but the requirement is for only one office. Office space could be used continuously or periodically by one or more full-time, or part-time representatives. If more than one Government representative is present at one time, then they will share the office. Explicit specifications are not provided, so Offerors are free to use their own judgement.

210. C.7.28 How will the Government determine a 15 minute travel time? Will this include time spent clearing base security, or will the Government provide office space on base to allow the contractor to meet the 15 minute requirement?

RESPONSE: The contractor will provide assurances and justification of their meeting the requirement. The contractor should not expect any on post/base office space to be offered.

211. C.7.28 Please provide the address of the Administrative Contracting Officer for each region.

RESPONSE: The current locations of the ACOs at the Lead Agents (to be renamed Regional Directors) are at http://www.tricare.osd.mil/ under the Lead Agent directory.

212. C.7.3 Do reconsideration or appeal rights apply to the contractor's determination of benefit coverage?

RESPONSE: No. There is no denial. The contractor informs the beneficiary of the non-benefit and the beneficiary then has the opportunity to decide whether to proceed with the care.

213. C.7.3 Does this provision indicate that the Government will require referrals for beneficiaries not enrolled in TRICARE Prime?

RESPONSE: No

214. C.7.3 May the contractor structure the review so that it also is a medical necessity review or a preauthorization review for services the contractor seeks to preauthorize for non-MTF enrollees?

RESPONSE: No

215. C.7.3.1. Can a beneficiary, whether or not an MTF Prime enrollee, refuse to go to the MTF and still have TRICARE cover the service? Can a beneficiary who needs a service that the MTF chooses to provide submit an appeal of the MTF determination? If yes, to whom?

RESPONSE: Yes. The coverage would be paid under the point of service requirements. The second part of your question is unclear; the MTF is offering to provide the care not deny it. There is no denial to appeal.

216. C.7.3.1. Does this requirement replace or complement the Non-Availability Statement?

RESPONSE: No

217. C.7.3.1. How quickly will MTFs respond to contractor offers of first refusal for civilian provider referrals? If the MTF does not respond within a certain number of hours or days, may the contractor consider that a refusal?

RESPONSE: The referral and response will be electronically and generally responses will be received within 24 hours. The contractor may not assume a refusal until an actual reply is received by the contractor.

218. C.7.3.1. Consistent with the solicitation's stated objective of providing beneficiary satisfaction at the highest level possible, this right of first refusal by definition would have to be real-time. How does the Government propose to implement this MTF requirement?

RESPONSE: Please note that this is in a HIPAA transition and will be in real time.

219. C.7.3.2. Do the MTFs have a similar data capture process for MTF enrollees? If so, will the contractor have access to draw comparative norms?

RESPONSE: The internal activities of the MTF referrals is outside the scope of this contract.

220. C.7.3.2. The requirement to refer 96 percent of referrals to the MTF or network is incongruent with the requirement to allow the MTF the right of first refusal. How can the contractor be responsible for meeting the 96 percent requirement when the contractor does not control the entire process?

RESPONSE: Your question is unclear. The contractor does control all the referrals received by it whether Prime, Standard, or Extra. Perhaps you are confusing the act of making the referral with the acceptance or rejection of the referral by the MTF?

221. C.7.3.2. Will the Government adjust the 96 percent requirement on a local basis if a significant number of providers decline to join the network because of factors outside the contractor's control (e.g., reimbursement rates, lack of appeal rights, or electronic claims submission requirement)?

RESPONSE: No

222. C.7.3.2. NCQA updates the HEDIS from time to time. Will the Government require the contractor to achieve the fiftieth percentile based on the most recent HEDIS version or based on the HEDIS version in effect at the time of solicitation issuance or award? Will the Government modify the contract each time it expects the contractor to comply with the revised HEDIS?

RESPONSE: ***revised 26 September 2002***
RESPONSE: The requirement to performance the HEDIS standards will be deleted in a future amendment and will be replaced with Government monitored quality assurance standards.

223. C.7.3.2. For the purposes of this requirement, do MHS beneficiaries include beneficiaries eligible only for direct care?

RESPONSE: MHS beneficiary is defined in the TOM, Appendix A.

224. C.7.3.3. Which health plans are included in the universe of all reporting plans—commercial, Medicare, Medicaid, TRICARE?

RESPONSE: All is all plans as reported by NCQA.

225. C.7.3.3. The active duty family population is very mobile. How will the contractor obtain, for example, immunization records from previous locations?

RESPONSE: The contractor will propose and the Government will evaluate the offeror's methods for fulfilling this requirement.

226. C.7.3.3. Are CAHPS measurements also included in the requirement?

RESPONSE: No

227. C.7.3.3. Will the Government make PDTS and other pharmacy data available so the contractor can collect HEDIS measurements that relate to pharmacy?

RESPONSE: ***revised 26 September 2002***
RESPONSE: PDTS data will not be made available to the Managed Care Support contractors. Please see the answer to Question 222.

228. C.7.3.3. To whom and by when does the contractor submit the annual report?

RESPONSE: The contractor submits the report to the Contracting Officer. The report would follow after the contractor submits its annual report to NCQA on meeting the HEDIS standards and after NCQA accepts it.

229. C.7.30.1. Experience has shown that Military Treatment Facilities are reluctant to include the Managed Care Support Contractors in contingency planning or mobilization support because of security concerns. Will the Government allow a small number of designated contractor personnel to have security clearances that would allow the Military Treatment Facilities to share information necessary for the contractor to participate (in a meaningful way) in the contingency exercises and any actual use of the contingency.

RESPONSE: If the MTF Commander determines that full participation in the contingency exercise requires clearances, the MTF will have to obtain the proper clearances for the appropriate people.

230. C.7.31. Please explain the scope of the Installation Level Contingency Exercise and the Regionally Coordinated Table Top Contingency Exercise.

RESPONSE: The MOU can give more specifics regarding the Installation Level and Regional Table Top Contingency Exercises should not be more than two days in length. These are activities, much like civilian mass casualty exercises, where we test the readiness of our response.

231. C.7.35 The MHS Enterprise Architecture web site is under construction; no information is available via the web site. Please provide additional information on any Government requirements related to hardware or software.

RESPONSE: The MHS Enterprise Architecture will be furnished directly to all

interested parties who obtained the data package.

232. C.7.36.2 For application of HIPAA standards, please confirm that TMA is the health plan and the contractor the business associate.

RESPONSE: That is not correct. Please refer to the chart in the TOM, Chapter 21, Section 2, paragraph 3.3.

233. C.7.37 Please clarify what read-only claims data the contractor should make available. Is the requirement to provide beneficiary-level data, provider-level data, summary data, or some combination of these?

RESPONSE: It is the same data that is required to be provided according to RFP Section C-7.21.2.

234. C.7.37. How often is training to be provided? Will it be provided centrally or at the work sites of the people listed in the requirement? Is the requirement for train-the-trainer or is it user training? Who is responsible for training that is needed as a result of turnover in personnel? What is the expected turnover rate for the group of staff identified?

RESPONSE: The contractor is expected to provide all and any training needed. The contractor will propose and the Government will evaluate the offeror's methods for fulfilling this requirement.

235. C.7.37. Please specify the location of the DOD TRICARE Operations Center and the number of personnel at the Center who will require access. In addition, will the contractor rely on the list of Health Benefits Advisors and Beneficiary Counseling and Assistance Coordinators provided on the TMA web site, or will the Government provide a list of these personnel who need access by Region?

RESPONSE: The current location is in Falls Church, VA and the number of personnel needing access is approximately 10. The current list of Health Benefits Advisors and Beneficiary Counseling and Assistance Coordinators provided on the TMA web site would be one method for the contractor to estimate the activity to meet this requirement.

236. C.7.37.1. - Please specify exactly what data the contractor must provide: claims data, customer service data, clinical data, patient specific data, case management files, financial data. Do all of the listed Government agents need access to all of the data? Does the
contractor need to summarize or analyze the data, or simply provide it in raw form? What does the Government mean by "unlimited."

RESPONSE: It is the same data that is required to be provided according to RFP Section C-7.21.2. There shall not be any restriction to viewing this data.

237. C.7.37.1. - It is understood that the contractor must provide the specified equipment for the on-site Government representative(s). For the other Government staff listed, does the contractor need to provide equipment for access or just authorization to access a contractor.

RESPONSE: The contractor is to provide only authorization to access, the necessary

training, and ongoing customer support.

238. C.7.37.1. - Is the authorization for the on-site Government representative for representatives located at both Prime and subcontractor locations?

RESPONSE: Yes

239. C.7.37.1. - Is there a minimum set of system interfaces to which the contractor should adhere? Are any of the interfaces web-based? If so, what is the Internet access capability of the listed Government agents and to what minimum set of requirements should any web interface adhere?

RESPONSE: No. The interfaces will be defined in the MOUs.

240. C.7.37.1. - How often is training to be provided? Will it be provided centrally or at the work sites of the people listed in the requirement? Is the requirement for train-the-trainer or is it user training? Who is responsible for training that is needed as a result of turnover in personnel? What is the expected turnover rate for the group of people listed?

RESPONSE: The contractor is expected to provide all and any training needed. The contractor will propose and the Government will evaluate the offeror's methods for fulfilling this requirement. Staff assignments for military individuals are generally of a 3 year duration.

241. C.7.39. - What type of information concerning the referral must the contractor provide and by what method? Should the contractor provide patient-level or summary data?

RESPONSE: The information must be furnished in a HIPAA compliant manner. The information shall include the name of the enrollee, date of referral, and the service for which the beneficiary is referred.

242. C.7.4. - Does the requirement to comply with TRICARE policy and regulation regarding review and approval of mental health services apply to beneficiaries who are enrolled to an MTF?

RESPONSE: No

243. C.7.4. - Even though review for benefit coverage cannot be a preauthorization review under C-7.3., please clarify how the contractor can use "best practices in reviewing and approving care" to determine both medical necessity and benefit coverage in C-7.4.?

RESPONSE: The contractor may propose preauthorizing care, except that the contractor's medical review authority for care authorized by the MTF is limited to the services required in C-7.5. The offeror may propose best practices that achieve the Government's objectives for the demand management of all other categories of beneficiaries.

244. C.7.4. - Does this provision require preauthorization review for all beneficiaries not enrolled to an MTF?

RESPONSE: For beneficiaries not enrolled to an MTF, preauthorization reviews are required for certain services; e.g., inpatient mental health, admissions to RTCs, care under the PFPWDs, etc.

245. C.7.4. - Do the words, "enrolled to an MTF," include both enrollees in TRICARE Prime and enrollees in TRICARE Plus?

RESPONSE: Yes

246. C.7.4. - Please provide the review requirements contained in the National Quality Monitoring Contract (NQMC) contract.

RESPONSE: ***revised 11 September 2002***

A copy of the current NQMC contract MDA906-97-D-0004 is available upon request and the MCS contract requirements related to the NQMC are contained in the TOM, Chapter 7. However, now that there are only 3 regions we recognize that the estimated quantities in the TOM need to be revised to 300-500 cases per region.

247. C.7.40. Does the Government expect to change the NQMC requirements? If so, how and when? Will the NQMC remain responsible for certifying certain types of facilities? Will the certification process or requirements change?

RESPONSE: ***revised 11 September 2002***

The RFP for the new NQMC is under development and the extent of changes is unknown at this time. The NQMC will remain responsible for certifying Residential Treatment Centers, Substance Use Disorder Rehabilitation Facilities, and Psychiatric Partial Hospitalization Programs. The standards for these facilities will remain as those requirements are specified in 32 CFR Part 199.6; however, the process could be revised. When the NQMC RFP is published (date not established), all of the requirements will be specified.

248. C.7.41. - Will the contractor receive other health insurance data from the Pharmacy Data Transaction Service contractor? If yes, how often?

RESPONSE: No

249. C.7.42. - Are the types of pharmaceuticals the contractor is required to cover those under the home infusion therapy benefit? Does this also include pharmaceuticals and devices injected at a provider's office?

RESPONSE: Yes to both questions.

250. C.7.42 Does the Government intend that the contractor will treat outpatient pharmaceuticals as covered benefits under this contract, as opposed to providing the actual pharmaceuticals to the beneficiaries?

RESPONSE: Yes